JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Question	Category	Response
Please describe the evaluation process and what tools will be used. For example, will one Evaluation Team review all the QAPI responses and a different Evaluation Team review all the Care Coordination responses, etc	Evaluation	The evaluation process will be described to the level necessary for Bidders' response in the published RFP.
UnitedHealthcare is a strong proponent of auto assignments algorithms based on health plan quality metrics and performance. What is HCA's proposed auto-assignment algorithm for new payers until the 50k membership is attained? Also, given the higher risk and unique features of Basic Health program, we suggest that new Basic Health members be distributed proportionally to all health plans so that the risk is spread amongst all plans, not just new MCOs.	Assignment	Thank you for your input! The assignment process will be described in the published RFP.
We suggest there be a separate assignment methodology for newly eligible groups like SSI. For these groups, all plans should be considered new to a Service Area.	Assignment	Thank you for your input! The assignment process will be described in the published RFP.
2. Section E, Assignment Methodology, significantly disadvantages existing health plan partners. Please distribute enrollees based on the overall RFP score or limit this policy to the first 6 month of the contract period.	Assignment	Thank you for your input! The assignment process will be described in the published RFP.
3. Assign new populations (SSI/AB&D) to qualified health plans in a consistent manner, based on the RFP scores, recognizing that all health plans are new to serving new population.	Assignment	Thank you for your input! The assignment process will be described in the published RFP.
4. Allow members to chose a health plan at enrollment instead of after assignment.	Assignment	As is currently true, all potential enrollees are and will be given a choice of managed care organizations (MCO). For Healthy Options, potential enrollees have a choice of at least two MCOs or they are not mandatorily enrolled. For Basic Health, choice may be limited to one MCO if only one MCO is available.
5. Assign additional points to health plans covering at least 80% of the service areas.	Assignment	Thank you for your input. The assignment process will be described in the published RFP.
6. Please assign enrollees who temporarily lose eligibility back to the health plan they were last enrolled in for continuity of care. In most cases at CHPW, these members are still being treated by our community clinics during their lapse in coverage without compensation.	Assignment	For Healthy Options, we reconnect enrollees to their prior MCO for one year. For Basic Health, enrollees must choose a health plan.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Generally, we think assignment should be used sparingly and sensitively with the SSI and MCS popula-tion. Before enrolling individuals with current health care needs in a health plan, HCA should be re-quired to work with them to determine what factors are important to them in making an informed choice. DSHS has already determined that many clients in this population require individualized plans under DSHS‘s -Equal Access‖ rules (formerly called -NSA‖ - necessary supplemental accommodations) by which the Department intends to codify some of its obligations under the Americans With Disabilities Act. See generally WAC 388-472-0010 - -0050 For patients who already have such plans andFor others who need them, the state may have a duty to assist with plan selection. Clients should be assisted with selection, using the provider overlap information provided by plans, specialty care needs, geographic proximity of available providers, etc. The goal should be that only patients who have no preference after reviewing multiple choices would be assigned to a plan.	Assignment	Thank you for your input. The assignment process will be described in the published RFP.
For the plan selection process (and assignment, when necessary) to work properly, it is critical for HCA to require not only the list of providers who intend to participate in a plan‘s network, but statements of actual availability to take new patients, including the maximum number of new and existing HO/BH pa-tients they will accept. Former members returning to the MCS program should be returned to their pri-or plan unless they affirmatively choose otherwise.	Assignment	Thank you for your input. For Healthy Options, we reconnect enrollees to their prior MCO for one year. For Basic Health enrollees must choose a health plan.
After efforts are made to assist people with plan selection, we suggest assigning people based on the proportions of people selecting each plan. For example, if 30% of the choosers chose Plan A and 70% chose Plan B, then assignments should reflect the same proportion (to the extent capacity exists). This assignment policy could be revised after the first year based on the results of state monitoring/audit and consumer satisfaction surveys. Allowing freedom to change plans at any time (i.e., no lock-in) will be an essential safeguard during this time of transition.	Assignment	Thank you for your input. The assignment process will be described in the published RFP.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Auto-assignment. Special provisions may also be needed around auto-assignment of homeless populations. The State should ensure that homeless enrollees can access experienced homeless health care providers in-network. When a homeless person fails to choose a plan during the enrollment process, it is important to attempt to identify the usual source of care and then assign the beneficiary to a plan that includes this provider in its network. To help inform the continued move to health homes, analysis should also occur to determine whether homeless enrollees are actually accessing services from the contracted provider, and under what circumstances care is sought from non-network providers. For too long we have had situations where the PMPM s being paid out to a given clinic/provider for the enrollee‘s care, yet significant levels of care management are happening in other portions of service system – portions that have been built up as -workarounds‖ because the structures of the managed care system and clinics were too difficult to navigate, or a client didn‘t even know that he or she was enrolled with a given clinic or provider. These –workarounds‖ may in fact hold critical keys to what effective care	Assignment	Thank you for your input. The assignment process will be described in the published RFP.
We are concerned that the assignment methodology is designed to favor new plans and does not put the interests of clients first. The assignment methodology seems intended to attract new providers (by guaranteeing them 50% of assignees, if we understand the methodology correctly). But there is no indi-cation that when an SSI clients are newly enrolled in a plan, their needs will be taken into account. If MCS patients are included in this contract, that is an issue for them as well.	Assignment	Thank you for your input. The assignment process will be described in the published RFP.
Topic: Assignment Methodology On Page 25, in Section E. Assignment Methodology, preference appears to be given to new players or plans entering into Healthy Options or new service areas. It would be helpful to understand why preference is being given to new players over those plans who have historically served populations in these service areas. The RFP includes new populations, as well as those populations that have historically been served in Healthy Options. This type of assignment methodology also seems to benefit the new players and plans as most of those new eligible‘s will potentially be assigned. Would the HCA consider a more equitable formula that is more favorable to those plans with historic presence and capacity, as well as those new players?	Assignment	Thank you for your input. The assignment process will be described in the published RFP.
What are the benefits? Will the same rules and benefits apply to all populations?	Benefits	The benefits for the programs that are the subject of the procurement will be described in the specific contract exhibits for the programs. Those will be available when the RFP is published.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Will WBH be a Medicaid look a like as far as benefits and costsharing?	Benefits	The Basic Health program will have a different benefit and cost sharing structure from Healthy Options.
Also missing is important information on benefits, including the scope of services, self-referral, what happens to enrollees hospitalized at enrollment/termination of enrollment, and any description of con-tracted services, coordination of benefits, and third-party liability. These are sections 14.1, 14.3, and 14.12-14.16 in the current contract. The draft contract refers to Exhibits, including A, B and H, which were not included. In addition, the current section 6.6 of recoupments and retroactive disenrollment is apparently omitted.	Benefits	The benefits for the programs that are the subject of the procurement will be described in the specific contract exhibits for the programs. Those will be available when the RFP is published.
5. Where/how does it define the scope of the benefit package that the contractor is responsible for providing? For example, how does the contractor know where its responsibilities for providing medically necessary services ends and ADSA's begins?	Benefits	The benefits for the programs that are the subject of the procurement will be described in the specific contract exhibits for the programs. Those will be available when the RFP is published.
Is WBH going to stay a subsidy program with deductible?	BH	BH will continue to be a subsidy program, where applicable
What type of items are being included in the bids?	Bidding	Bid contents and structure will be addressed in the published RFP.
Further, it has been our experience in other states that have recently conducted Medicaid managed care procurements that the intial contract term is at minimum a three year period	Bidding	The contract period for the contract resulting from the RFP is February 1,2012 through December 31, 2013 with two one year renewals at the option of HCA.
Can HCA confirm the preference for statewide payers during the RFP and any potential rewards.	Bidding	It is HCA's preference that potential enrollees have as many choices of quality health plans as possible. The RFP will include a description of the evaluation process.
Will existing HO/BH plans be required to respond to this section in detail given evaluators will have past monitoring reports?	Bidding	Bidders should respond as directed in the RFP. Evaluators will have the results of HCA's past monitoring and Bidders will not be required to resubmit such results, but all Bidders will be required to submit results from other states.
3) 2) (Note: Attached reports excluded from page count.) Provide all results of any state, federal or other independent monitoring for the last three years, 2008, 2009 and 2010, of the Bidder's performance in Care Coordination for managed care programs serving low-income populations in other states. Evaluators will have past monitoring reports for Washington for evaluation.	Bidding	Bidders should respond as directed in the RFP. Evaluators will have the results of HCA's past monitoring and Bidders will not be required to resubmit such results, but all Bidders will be required to submit results from other states.
4) 3) Present anything other information that you believe will enhance your response	Bidding	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

h. Understanding of the Changing Landscape of Healthcare Managed Care (Binder 9) The health care world is experiencing change and transformation. It is important for Bidders for the services that are the subject of this Procurement to understand, be adaptable to and be innovative leaders in that change. Convince us that you are that Bidder! (Limited to 10 pages) Describe to how the Bidder will help Washington state during the contract period move toward achieving the Three-Part Aim of better health for the population, better care for individuals, and reduced cost or better managed growth in costs. Use the follow healthcare reform principles as an initial framework for your response, revising or adding principles as appropriate.	Bidding	Thank you for your comment. HCA will take this under advisement
For Binder 1, we note that bidders are to list the amendments they have downloaded from the procurement website. We suggest that instead of this process, or in addition to it, HCA provide its full list of issued amendments and let contractors use that as a check list for confirmation. This would assure that bidders are informed of all amendments and have a precise method of „inventorying" all relevant documents.	Bidding	Thank you for your comment. HCA will take this under advisement
For Binder 2, the specification doesn't include submissions in this binder in the -excluded from page count‖ policy, but we suggest that HCA establish a process by which a bidder can request a waiver of the 100 page count maximum. The reason for this is that some bidders who contract in multiple states may need to submit reports that are in excess of 100 pages.	Bidding	Thank you for your comment. HCA will take this under advisement
Electronic information regarding eligible clients, provider and claims data should be provided to Bidders on or before the RFP release date. Providing data after the letter of intent is due (September 12th) is too late to review and act on the information before the RFP due date.	Bidding	Thank you for your comment. HCA will take this under advisement
The draft RFP does not ask bidders to describe their experience and/or capabilities providing capitated services to aged, blind and disabled (ABD) populations. We suggest that HCA consider adding as part of the RFP a section and/or questions that assess the bidder's experience in providing services to SSI populations and how the bidder intends to address the unique needs of this population under managed care	Bidding	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Additionally, the draft RFP and the draft Health Options, Basic Health and Disability Lifeline contract template is silent on 1.) the specific client groups eligible for mandatory enrollment under the procurement, and 2.) a description of the scope of covered benefits and services that the contractor will be responsible for providing. In order for bidders to have a better understanding of the services that will be included and the provider network that will need to be in place to provide these services to the covered population it would be helpful if the final draft RFP and sample contract included this information	Bidding	The information will be in the exhibits, which were not included in the draft.
We also recommend a competitive rate setting process to allow new entrants an opportunity to be competitive during the bidding process ~Providing a comprehensive databook to all vendors will ensure all vendors an opportunity to compete with rates	Bidding	Thank you for your comment. HCA will take this under advisement
Understanding the Managed Care programs in Washinton State at a macro level specific to providers, hospitals, data analytics, and problematic health programs is an advantage. Existing managed care companies have built a level of knowledge of the local market that if not balance and accounted for in the way the process is structured during the RFP will favor certain bidders and disadvantage others, especially new entrants. We recommend the following: Section 2a.) Quality Assurance and Performance Improvement; Section 2. d.) Grievance System; Section 2.E.) Utilization Review and Authorization of Services and Section 2. f.) Program Integrity require bidders to provide results of any state, federal or other independent monitoring for the last three years in managed care programs serving low income populations in other state creates an unlevel playing field for bidders that have an extensive footprint nationally compared to a plan that may participate in just one or a handful of states.	Bidding	Thank you for your comment. HCA will take this under advisement
Further, it is unclear how the <above> information could be fairly evaluated amongst the bidders. To be more equitable, we would suggest that HCA consider modifying the language to allow bidders to satisfy this requirement by submitting results of any state, federal or other independent monitoring or a managed care program that either is the bidder's largest (in terms of covered lives) or longest standing program.	Bidding	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 2.b.) Access to Care and Provider Network (p. 20) states that HCA will provide each bidder that submits a Letter of Intent with an electronic copy of file that list the providers with claims in the previous twelve months, sorted by Service Area, for potential enrollees in populations that will be transitioning from HCA's fee-for-service to managed care. According to the draft Procurement Schedule (p.9) the Letter of Intent is not due until September 12, 2011. United Healthcare respectfully requests that HCA allow bidders to submit a Letter of Intent prior to this deadline in order to receive the provider file earlier than September 12, 2011. This provider information is pivotal for targeting high volume and traditional Medicaid providers for contracting purposes and to ensure continuity of care for new populations that will be covered under managed care. Further, the delay in receipt of this information has the potential to create an unlevel playing field between current Health Options plans that already have a network in place and new entrants just building networks	Bidding	Thank you for your comment. HCA will take this under advisement
• Each plan should be specifically asked and evaluated according to how it plans to implement our state‘s mental health parity law. Right now Healthy Options participants with mental illness qualify for either RSN services or the much more restrictive Healthy Options mental health benefit. Parity would require that treatment for mental illness be just as available as treatment for cardiac disease, for example. Plans should be asked to show how care will be delivered according to medical necessity and not according to some of the strategies that have traditionally restricted access, such as limitations on visits, prior authorization practices applied more heavily to mental illness treatment, payment methodologies that treat psychiatric providers as different from other categories of physicians, coding restrictions, and so on. Treatment services for substance abuse and dependency require similar parity, in our mind.	Bidding	Thank you for your comment. HCA will take this under advisement
4. Is it accurate to infer that all -program subsections‖ are to be weighted equally at up to 100 points in the selection of successful bidders?	Bidding	No, the number of points is the same. The weights and the use of those weights will be described in the published RFP.
Is it accurate to infer that all -program subsections‖ are to be weighted equally at up to 100 points in the selection of successful bidders?	Bidding	
1. Contract, Definitions and Section 2, General Terms and Conditions Can the HCA provide further direction in what is being sought in the response a Bidder should prepare in providing an Implementation and Operations Plan for these sections	Bidding	The sections of the contract that require a response and the format of that response will be clarified in the published RFP.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

For the Implementation Plan required for Section G, all requirements not identified separately in other sections encompass a significant portion of the contract. Can the HCA provide additional direction in how they would like to see this presented? Separated by contract section or other methodology? Is each contract requirement to be addressed individually?	Bidding	The sections of the contract that require a response and the format of that response will be clarified in the published RFP.
What data elements will HCA require in a network provider file for the RFP? Bidders whose networks consist of providers under LOI's may have a limited set of data pending completion of provider contracts and credentialing after awards. The draft RFP did not specify provider data file requirements. We would recommend the following for purposes of the RFP submission: Provider Last Name, Provider First Name, Provider Middle Initial, Provider Primary Specialty, Provider Secondary Specialty, Provider Type (Practitioner, Hospital, Pharmacy, Clinic, Other), Provider NPI, Group or PracticeName, Group NPI, Each Service Location Street Address, City, State, Zipcode.	Bidding	This information will not be available until the RFP is released.
Bidding Structure - Will plans bid for statewide contracts or would this be perhaps segmented more narrowly (i.e. perhaps bidding would be done by a region)? - Would plans be bidding for all three of the populations (TANF, Basic Health, SSI) combined or perhaps instead would they would able to bid for just TANF, or just Basic Health, etc?	Bidding	It is HCA's goal to have a choice of plans and statewide coverage. Bids will be by county/service areas. Those plans that are bidding must bid on all populations.
13.Section 1 (Purpose) notes that successful bidders will be expected to have in place a network to adequately meet the needs of the individuals in the service area(s) the bidder proposes to serve. We assume that network adequacy will be assessed during the readiness site visits, which per the schedule will occur between February 1 and May 31 (a four month period). Since network development is a continuing process, a contractor's network is likely to be more complete at the end of this period than at the beginning. Will HCA establish a process to ensure that all contractors have the same amount of time for network development, and that no contractor is disadvantaged in this assessment?	Bidding	Bidders will be expected to have in place a network that meets the needs of individuals in the service area at the time of the bid. The network may be partially based on letters of commitment from providers. For bid evaluation we can only objectively evaluate what we are able to see. We will evaluate networks in the readiness assessment, but that assessment will not figure into scoring but rather confirm what was proposed and any corrective actions.
Please confirm, per the Joint Procurement Informational Presentation earlier this spring, that although Bidders must hold a current Certificate of Registration from the Office of the Insurance Commissioner, they do not have to have an approved service area within a proposed region to submit a bid.	Bidding	It is not necessary to have a network approved by the OIC, but it is necessary to demonstrate to HCA's satisfaction the adequacy of the network.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

RFP Section C.2.b refers to -Committed‖ providers, defined as those –with whom Bidder has a written commitment to enter into a contractual relationship if the Bidder is awarded a contract‖. Can -written commitment‖ be interpreted as inclusive of Letters of Intent (LOI)? Our experience as a new entrant in other states is that providers are reluctant to review or sign contracts or formal agreements or to complete credentialing until they have assurances that the MCO has received a state Medicaid contract. Many states utilize Letters of Intent (LOI) for RFP evaluation purposes. If provider contracts or more formal commitments are required, this may preclude non incumbent, but highly qualified, MCOs from participating. We have included an example LOI for reference and acceptability.	Bidding	As long as the letter of intent convincingly demonstrates the commitment of the provider to enter into a contract, it will be sufficient.
It is clear Bidders may not bid for part of a Service Area. Are plans required to bid on all programs (HO, BH, SSI) in each Service Area a bid is submitted?	Bidding	Yes
In the draft RFP Section A.2.d, it identifies that a –Bidder must be currently contracted in some state to provide Medicaid managed health care services.‖ Please clarify that Bidders may utilize affiliate health plan experience to meet this requirement. Our organization (and we anticipate this to be the case with other National companies) will establish local subsidiaries, and while these are technically new entities, these new local entities are able to draw upon, and benefit from, the breadth and depth of experience across the entire organization.	Bidding	Yes, as long as the availability of the depth of experience to the State of Washington is clear in the response.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

For several sections of the RFP (complete list at the end of this question), HCA requests the Bidder to -provide all results of any state, federal, or other independent monitoring for the last three years, 2008, 2009, and 2010 of the Bidders [various subject areas] in managed care programs service lowincome populations in other states,‖ or similar language. a. Please confirm that affiliate health plan experience can be used in responding to this question. b. As a follow up to (a), we recommend that the HCA consider limiting this question to submission of this information for up to 3 additional states. As some companies maintain contracts with health plans in numerous Medicaid programs across the country (10+), providing this information across each program would be a voluminous amount of information. c. We recommend that HCA narrow the scope of these questions to be more specific in the types of reports or documentation being requested. In many Medicaid programs, depending on state specific requirements, the volume of reports submitted related to these various topics may exceed several hundred reports per year. It may be difficult for Bidders to determine exactly what information HCA would like to receive based on the broad language and ambiguity in these questions. For example, Question 2.d.2 could be revised to request the annual complaints and grievances summary report (or equivalent) submitted to a	Bidding	Affiliate results are responsive. All results are required since the inclination would be to choose the favorable results. Thank you for the input.
Per page 20, Section B, geographical analysis should –(c) Show the number of providers and percentage of eligible‘s that have a contracted or committed provider within 5 miles, 10 miles, 15 miles, 25 miles, 35 miles and 50 or more miles.‖ a. If the Bidder achieves 100% accessibility at any of the given points, do they still need to demonstrate percentage and provider counts at the larger mileage measuring points? For example, if 100% of the members achieve access in the 10 mile category, does the Bidder still have to provide the same reports demonstrating 15, 25, 35, and 50+ miles? b. Will the state confirm the access standards in this section are for one provider within –N‖ number of miles?	Bidding	Thank you for the input. Expectation for response will be clarified in the published RFP.
Will Bidders be required to register for the WEBS website, or will the HCA website referenced in this section be functioning when the RFP is released?	Bidding	No, bidders are not required to register for WEBS. HCA will post a notice on the WEBS website to advise potential bidders that the RFP and all related documents are now available on the HCA's webpage. HCA will also notify potential bidders through direct e-mail when the documents become available.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Binders 2-8 include the following language: -Provide all results of any state, federal or other independent monitoring for the last three years, 2008, 2009 and 2010, of the Bidder's performance in _____managed care programs serving low-income populations in other states. Evaluators will have past monitoring reports for Washington for evaluation.‖ Please explain what, if anything, is required of the currently contracted Healthy Options/Basic Health plans?	Bidding	Currently contracted health plans are required to provide the results of any monitoring, in any state, that was not conducted by HCA (MPA). The expectation will be clarified in the RFP.
Are bidders required to have Washington Electronic Business Solution (WEBS) account?	Bidding	No.
Must bidders contract with community partners? There is no reference or direction indicated?	Bidding	Basic Health partners with many organizations around the state to help applicants and members. The HCA does not require these organizations to contract with the health plans, but does expect the health plans to work collaboratively with these organizations wherever possible to assist enrollees and applicants.
All sections request a comprehensive Implementation and Operations Plan that addresses all requirements of the specific identified section, or in the case of Section G all requirements not identified separately in other sections. In cases where the contract refers to a policy and procedure, is the HCA requesting submission of the specific policy and procedures or only that one exists within in the implementation plan?	Bidding	The Implementation and Operations Plan is the plan to achieve and maintain 100% contract compliance by and after July 1, 2012.
Each section requests results of any state, federal or other independent monitoring for the last 3 years, 29008, 2009 and 2010. Then further states that Evaluators will have past monitoring reports for Washington for evaluation. If a plan participates in Medicaid, only in Washington and no other states, what if anything should be provided to meet the requirements of these sections?	Bidding	Currently contracted health plans are required to provide the results of any monitoring, in any state, that was not conducted by HCA (MPA). The expectation will be clarified in the RFP.
For Binder 8, All Other Contractual and Regulatory Requirements, we are concerned that the potential subject matter/content of responses in this category is very broad and vague. There are of course specific, programmatic elements described in g.1) and g.2), but we would like to have additional, concrete guidance from HCA as to its minimal expectations for an acceptable response to this section.	Binder	The sections of the contract that require a response and the format of that response will be clarified in the published RFP.
Additionally, there is no explanation for the elimination of plan capacity standards (in current contract at section 7.2.4, 7.2.5, and 7.3). What is the reason for this? If there are no capacity standards, how would adequate capacity be ensured?	Capacity	The contract does have standards for network adequacy. It does not have a plan set capacity as an element of assignment.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

c. Care Coordination (Binder 4) Review the Care Coordination requirements in the Sample Contract and relevant federal requirements in 42 CFR 438. 1) Submit a comprehensive Care Coordination Implementation and Operations Plan that describes in detail how the Bidder would have in-place and operate Care Coordination that meets all contractual and regulatory requirements and fully meet the needs of the population to be served beginning July 1, 2012. 2) Submit an Allied System Coordination Plan that describes in detail how the Bidder will have clarified the roles and responsibilities of allied systems in serving persons mutually served. This includes processes for sharing information related to eligibility, access, and authorization; identification of needed local resources, including initiatives to address those needs; a process for facilitation of community reintegration from inpatient and institutional settings; and a process to evaluate cross-system coordination and integration of services. This will include coordination with local, county and state managers of allied services and supports including: Management; infants from the ages of birth to three; enrollees who meet the criteria identified in WAC 388-501-0135; children with special health care needs;	Binder	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

1. Care should be organized through person-centered health homes that integrate mental health care, substance use assessment and treatment, oral health care and comprehensive primary care. The organization of these services should be based on the Chronic Care Model and described by Dr. Ed Wagner and colleagues at Group Health Cooperative of Puget Sound. 2. Each health home should eventually be part of an Accountable Care Organization (ACO) that includes appropriate and timely access to specialty care, inpatient care and long-term care coordination. 3. Care should be evidence-based and include appropriate preventive services. Health plans, health homes, and ACOs should support the delivery of primary, secondary and tertiary prevention services and supports. 4. Health plans, health homes and ACOs should ensure that systems are in place to ensure high-risk, high need populations receive appropriate care management and needed wrap-around services. 5. Within health homes, primary care, substance use and mental health staff must be able to care for clients within all quadrants of the National Council for Community Behavioral Healthcare Four Quadrant model; this includes collaborating with mental health and substance use providers to obtain psychiatric, crisis and involuntary commitment (ITA) services, inpatient treatment for substance use, and psychiatric hospitalization, as necessary.	Comment	Thank you for your comment. HCA will take this under advisement
The RFP and the Contract do not include or require coordination with housing, employment, social services and criminal justice. We recommend that the RFP/Contract require that the health plans, through Accountable Care Organizations, provide coordination for housing, employment, social services and the criminal justice system.	Comment	Thank you for your comment. HCA will take this under advisement
We recommend you attempt to reduce complexity whenever possible. We are particularly concerned about pharmacy management practices that are often so complicated that individual prescribers spend inordinate amounts of time trying to figure out what medications a given client can get and what procedures one must go through to get the medication. As we are facing a shortage of primary care providers (as well as psychiatric providers), we cannot see a justification for large amounts of valuable patient care time being spent in these matters. Complexity can affect clients as well, undermining adherence with medical recommendations and thereby leading to negative outcomes.	Comment	HCA is very committed to reducing complexity whenever possible. We will continue to work on this with our health plan partners.
The claims payment standards provided under the RFP do not match the provisions in state rules. For example, under current rules, plans must pay ninety-five percent of clean claims within thirty days.	Comment	We will review the rules for state and federal compliance.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 9 – Enrollee Rights and Protections: Comment: Sub-section 9.2. Cultural Considerations: The Contractor shall participate in and cooperate with the Health Care Authority' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 CFR 438.206(c) (2)).	Comment	Thank you for your comment. HCA will take this under advisement
General Comment on Enrollee & Stakeholder Involvement – Overall, the draft contract does not address any requirements of MCOs to involve consumers/families in the planning, development, and implementation of service delivery. Consumers/families voices are critical for making sure that service delivery system meets and continues to meet the needs of individuals/families served. Recommendation: Incorporate the requirement of MCOs to have individuals/families voices at all levels ranging from policy-decision making, system quality improvement discussion to service design and implementation level.	Comment	Thank you for your comment. HCA will take this under advisement
The proposed contract and the RFP fails to address the role of counties or any required coordination or consultation with counties.	Comment	Thank you for your comment. HCA will take this under advisement
New language indicates that transitional healthcare by a PCP must be available 48 hours post discharge from hospital or behavioral health clinic. We recommend the language be changed to the later of 48 hours or next business day to account for holidays and weekends. Also, some members may be difficult to reach, unwilling to be seen or not engaged in the process. As a result we suggest, in addition to the above change, we believe the language should be changed to -make a good faith effort to schedule a visit within 48 hours‖.	Comment	Thank you for your comment. HCA will take this under advisement
Mental health and chemical dependency benefits should be included in the contract for all populations. This will maximize savings to the state and provide the most effective coordination.	Comment	Thank you for your comment. HCA will take this under advisement
We suggest short and long term goals be changed to -prioritized‖ goals. NCQA requires prioritized goals and this would streamline documentation.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

We appreciate language in the RFP that moves towards these requests, but believe that there are areas where the state can go further in the RFP and contract requirements. • We believe the language requiring health plans to coordinate care should be strengthened. We are concerned that the lack of specific references to substance abuse services and the crisis system (including involuntary commitments and hospitalizations) will leave responsibility for services undefined, and therefore the local communities may end up responsible for the unspecified costs. We appreciate the language that requires health plans to coordinate with Regional Support Networks for mental health services, however, we believe it is also important to include substance abuse services that are also delivered at the county level. We request that the state include further detail and definition for these services. The language in the current Healthy Options contract more fully provides standards and structure related to behavioral health services and we would welcome an opportunity to further discuss the inclusion of some of the more detailed language in the current contract into this contract.	Comment	Thank you for your comment. HCA will take this under advisement
• It is important for the plans to be required to provide appropriate and timely access to specialty care, inpatient medical care, long-term care and substance abuse treatment, including outpatient and inpatient substance abuse treatment.	Comment	Thank you for your comment. HCA will take this under advisement
• Local communities across the state of Washington range from urban to rural/frontier and also include counties that are made up of islands. It is important for the health plans be responsive to unique local needs and conditions.	Comment	Thank you for your comment. HCA will take this under advisement
• County human services departments and the criminal justice system use local resources to develop and coordinate systems of care to support individuals in the community. Accountability for services and outcomes must be required from the plans along with responsibility for referral to services in order to maintain the important care coordination within the system. It is important that these important services and leveraged funding sources be included in service delivery by coordinating care with housing, employment, social services and criminal justice.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Implications on hospital payment: hope the department will also engage in a thoughtful process to review many of its hospital payment programs that hinge on fee-for-service claims. We understand this issue is outside the scope of the RFP, but planning needs to begin for how an expanded managed care program will affect payments under the Certified Public Expenditure program, trauma care payments, and Disproportionate Share payments.	Comment	Thank you for your comment. HCA will take this under advisement
We would recommend the use of Interqual medical criteria in lieu of -utilization management requirements‖ in order to provide a consistent framework across all plans and providers. For example, the state allows payment for short stay admissions which some plans use utilization management to reclassify as outpatient procedures. We would like to have consistent interpretations across programs.	Comment	The HCA requires additional information before it can respond to this question.
Partnering with our community. In terms of the overall RFP and contract approach, we believe that a key factor in evaluating responses should be the extent to which the managed care organization (MCO) has a demonstrated ability and intent to integrate health services with community, public health, and social services. We note that little information is provided to prospective respondents about the populations that they would be serving, the current health care systems and environment in different counties, and the goals and challenges each county faces in working to improve health care access, quality, and coordination for the Medicaid population. It strikes us that any managed care organization (MCO) seeking to do business in our community should demonstrate a solid understanding our of local issues and partners. We recommend that Washington State look at examples from other states, such as Minnesota‘s current RFP for managed care, in which county-level information and recommendations – including public health – are conveyed to prospective MCO bidders.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Business practices. It is also essential that applicants demonstrate sound business practices and that they can offer access to an adequate provider network and sustain cost controls over many years. In King County, as MCOs have come and gone, we have seen the -on the ground‖ care coordination problems that have ensued, including confusion for vulnerable patients and the case managers and providers working with them. If our intent is to move toward a truly client-centered system of care, the practices and stability of managed care contractors warrant increased scrutiny. Specifically, respondents should: Have good standing in other states with regards to criminal and civil lawsuits, and regulatory enforcement actions. Demonstrate longevity of commitment to patients and providers under other state programs, and willingness to commit to long term contract in Washington State. Document a history of good clinical quality, strong performance with the target population and a history of positive relationships with providers. Demonstrate competence and effective health information technology to minimize improper denial of claims, and ensure high rates of accurate and timely claims payment. Guarantee a majority of business activity (including customer	Comment	Thank you for your comment. HCA will take this under advisement
Preventive Services and Health Promotion. Given the important role that clinical preventive services and health promotion play in assuring the health of enrollees and in containing health care costs, we recommend that the State take the time to revisit the RFP through this lens and incorporate requirements and expectations for the integration of preventive services. In the current draft RFP, there are very few mentions of preventive services – it mainly appears in the form of a requirement for the Contractor to provide enrollees with written information, which is clearly insufficient.	Comment	The HCA will add language in the practice guidelines section requiring the MCOs to produce a practice guideline on preventive care services.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

In its managed care contracting, the State has an important opportunity to begin taking steps to shift our system to one that places a greater emphasis on health promotion and prevention, rather than one that treats only illness and injury. In some respects, the RFP seems to still largely reflect our current system's way of doing business, and could be stronger in incorporating the vision for prevention that was articulated in the recent Global Medicaid Modernization Initiative proposal and in the Department of Health's Agenda for Change.	Comment	We will ask MCOs to: 1) Develop health promotion and preventive care educational materials for enrollees using print and electronic media; 2) Conduct outreach to enrollees to promote timely access to preventive care according to MCO-established preventive care guidelines; 3) Report on preventive care utilization through required performance measure reporting; and 4) Disaggregate data on at least one preventive care measure and examine the data for racial/ethnic disparities; 5) Target interventions to enrollees with known disparities in preventive care utilization and measure the impact of the interventions on utilization patterns.
Section 12.6.5, regarding coordination with other service systems, is a critical section of the RFP yet is buried and could benefit from further discussion and examples that convey the reasons that these areas of coordination are so critical. For example, section 12.6.5.7 references Health Department coordination, yet is silent on important potential areas of collaboration such as the integration of clinical preventive services into the managed care network; population-based services through such strategies as the use of community health workers; and coordination of chronic disease management activities.	Comment	Thank you for your comment. HCA will take this under advisement
In addition, the RFP may be strengthened by incorporating more intentional language regarding health homes and the role of the managed care contractor in supporting their functions and goals. While this is reflected in a general way in Section 12.6's Coordination of Care section, there appears to be little discussion of the health homes model and establishing a team approach, evidence-based care model. Health Information Exchange is a tool that is necessary to enable the effective coordination of a health home, and health plans should be involved in their development and in exchange activities. While 12.6.2 references information sharing, this is different than participating in local and regional efforts to design HIEs and work across different health care entities to improve care coordination.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Homeless and Criminal Justice Involved Populations. Another area of significant concern to us—based on our current experience with the Medicaid managed care plans – relates to those enrollees whose social conditions and poor health result in complex care coordination challenges. As we move toward 2014, more of these populations are expected to be covered under Medicaid expansion. Therefore, it is important that this next period of managed care contracting take steps to improve the care management services for the high-risk, high need populations. Particular attention is needed regarding outreach, enrollment, care management, and quality improvement practices in order for the State to achieve the planned cost containment. This RFP is an important opportunity to make progress in that direction. In Section 12.6.5. we recommend adding a category calling for coordination with -Homeless services, such as outreach programs, shelters, day programs, recuperative care programs, homeless health programs, and transitional and permanent supportive housing.‖ A category should also be added regarding coordination with jail and correction health services programs, with steps taken to minimize the care	Comment	Thank you for your comment. HCA will take this under advisement
Tracking homeless status. The managed care entity should identify homelessness status of enrollees and this should be a marker for increased health risk and possibly for specialized care management services (for example, don't assume the enrollee can be reached by telephone or mail; anticipate usage of specialized homeless health programs and crisis diversion programs and the need to coordinate, etc.). The State should assure that homeless status is part of the Medicaid application and the data maintained by the Contractor. In the Section 6.5 on data to be reported on enrollee mortality, homeless status should be a required data element. Knowing an enrollee's housing status is a key element in effective care management, in quality improvement activities, and in the ability to correctly analyze the cost and utilization patterns of this group of enrollees.	Comment	Thank you for your comment. HCA will take this under advisement
ELIGIBLES: RFP states duals will not be included and state website mentioned duals will potentially be included. We recommend making duals separate.	Comment	Persons eligible for both Medicaid and Medicare are not subject populations for the RFP.
COST: We recommend providing data books with electronic data available and rates in the RFP	Comment	Thank you for your comment. HCA will take this under advisement
1. Remove Disability Lifeline from the RFP. This is a very small program of members who have been benefitting from an unique model of care that is demonstrating positive impacts on homelessness, arrests, hospital costs and health outcomes. Dividing this program's enrollees up among multiple health plans will cause disruption to care for a vulnerable population.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Care would have to be provided within person centered health homes that integrates mental health care, substance use assessment and treatment, oral health care and comprehensive primary care The person center health homes would have to provide care based on the chronic care model By definition, each health home would have to be part of an Accountable Care Organiztion (ACO) that includes appropriate and timely access to speciality care, inpatient care and long-term care coordination Health homes could have to be part of ACOs that provide coordination with housing, employment and social services as well as coordination with the crimal justice system ACOs would have to provide a quality assurance plan to monitor and measure progress toward specific health outcomes and report these outcomes to all state and community partners All providers within each ACO would have to use a common, integrated electronic health record (HER). These providers would include primary care providers, specialty care providers, inpatient providers, mental health providers, substance use treatment providers and oral healthcare providers. EHRs used by different ACOs would ahve to be able to communicate with each other Care must be evidence-based and include appropriate clinical preventative services	Comment	Thank you for your comment. HCA will take this under advisement
The RFP and Contract lack specifics on person-centered health homes. We recommend that the RFP and Contract should include specific information on these homes, including co-management of patients with co-morbidities and co-location of integrated services	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

While the RFP and Contract require health plans to coordinate care with Regional Support Networks for mental health services, the description is vague and lacks any reference to substance use services. We recommend that the Contract require health plans to formalize contracts or Memos of Understanding with each County and Regional Support Network to identify the responsibilities and payment mechanisms to ensure adequate coordination and provision of mental health and substance abuse services. In addition, the RFP and Contract do not require plans to be accountable for psychiatric, crisis and involuntary commitment (ITA) services and to provide psychiatric hospitalization as necessary. We are concerned that without clear language, the plans could pass these responsibilities and costs onto local communities. We recommend that the RFP and Contract require health plans to care for patients using the National Council for Community Behavioral Healthcare Four Quandrant model; this includes collaborating with mental health and substance use providers to obtain psychiatric, crisis and involuntary commitment (ITA) services and psychiatric hospitalization as necessary. We also recommend	Comment	Thank you for your comment. HCA will take this under advisement
While the RFP and Contract describe coordination of care, they do not address accountability for this coordination or outcomes. We recommend that each health home would have to be part of an Accountable Care Organization that ensures appropriate and timely access to specialty care, inpatient medical care, substance abuse treatment, including outpatient and inpatient substance abuse treatment, and long term care. In addition, to ensure that plans are providing integrated, coordinated care, we recommend that the RFP and Contract require plans to collaborate with other funding sources, included, but not limited to, insurance, state and federal grant funding, county government, tribal government, and Reigional Support Networks	Comment	Thank you for your comment. HCA will take this under advisement
The RFP and the Contract do not incude or require coordination with housing, employment, social services, and criminal justice. We recommend that the RFP/Contract require that the health plans, through Accountable Care Organizations, provide coordination for housing, employment, scocial services and the criminal justice system	Comment	Thank you for your comment. HCA will take this under advisement
Although the RFP and Contract describe chronic care management services, the description is vague. We recommend that the RFP and Contract require health plans to adhere to the chronic care model as described in the literature by the Robert Wood Johnson Foundation at http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.	Comment	Thank you for your comment. HCA will take this under advisement
We recommend that the RFP and Contract include language that requires health plans to provide clinical preventive services as well as health promotion services	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

We are concerned that the RFP and Contract do not require health plans to be responsible to unique local conditions. To ensure that the current and future health care delivery systems are responsible to unique local conditions, expertise, and energy, we recommend that the Washington Healthcare Authority writes RFPs and develops Contracts that encourage and support Regional Healthcare Authority structures throughout Washington State	Comment	Thank you for your comment. HCA will take this under advisement
For people with serious health problems, particularly those in the SSI program, continuity, quality and convenience all may affect the course of an illness, recovery from an injury, or maintaining stability. For this reason, having an enrollment process that ensures the best fit between enrollee and plan is critical. The draft contract provided does not explain how this will be handled. Information about exemptions, disenrollment, and assistance to clients in plan selection is absent.	Comment	This activity, enrollment, is an HCA function. The RFP is to purchase health plan services and will not address HCA functions unless it would be necessary to prepare a response.
Finally, we noticed that CAHPS- based non-clinical performance improvement projects based on enrollee satisfaction are no longer included as a potential state-required activity (current contract, sec. 8.2.8). We think that state flexibility to require such projects in a situation in which CAHPS identifies enrollee dissatisfaction should not be eliminated, especially in a year when new plans may be participating.	Comment	HCA does not preclude an MCO from conducting the CAHPS or alternate enrollee survey. For now, the HCA has decided not to include the requirement in the contract.
Regarding authorizations and the -grievance system,‖ the proposed provisions need revisions so that the requirements for Contractors conform to those that apply to the Department when services are de-nied, reduced, suspended, or terminated. Moreover, some redrafting is needed to conform the require-ments to federal Medicaid managed care law and to state health carriers and health plans regulations, in part to overcome the confusion that may result from those regulations using different definitions of what constitutes a -grievance‖ and an -appeal.‖ The agency should take this opportunity to rationalize the confusing use of these terms, in which –grievance‖ sometimes means all kinds of complaints (including appeals and hearings) and sometimes the specific non-appeal complaint procedure. We sug-gest changing the all-encompassing title for part 11 of the Contract to -Complaints‖ or -Dispute Resolu-tion.‖	Comment	We will review the requirements. We use federal definitions. We harmonize state and federal requirements when possible, but federal requirements and terms have precedence. Thank you for your suggestions.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Follow Bright Futures Recommendations for Preventative Health Care including payment for: 1. immunization administration 2. dental disease prevention services: oral evaluation, oral health education, and flouride varnish application 3. developmental and autism screening at standard ages of 9, 18, and 24-30 months on all children and when concerns are raised to age 5. 4 15 month, 30 month and yearly exams after 3 years of age in addition to routine checkups at 3-5 days, 2 weeks, 2,4,6,9,12,18, and 24 months. 5 Care Coordination 6. After hours care 7. Access to quality mental health care appropriate for children including cognitive behavioral therapy and access to child psychiatric consultation	Comment	Funding to implement expansion of the child-adolescent periodicity schedule, developmental screening, after-hours care and care coordination is limited at this time. However, MCOs are free to contract with clinics for these services, including establishing a payment mechanism in the context of the contractual language associated with medical or health home. The MCO must follow standards established in contract for medical/health home.
Predicted Cost Savings 1. Decreased emergency room utilization as after-hours care provided in medical home unless true emergency. 2. Decreased hospital stays as critical illnesses seen earlier with better care coordination for children with special health care needs. 3. Decreased formulary costs as geenerics first utilized. 4. Decreased expenditures on dental surgery/procedures	Comment	The HCA acknowledges that these measures are appropriate for examining the impact of medical or health homes. These measures could be used by MCOs to validate the success of medical or health homes.
Other goals 1. Improved patient and family satisfaction. 2. Improved quality of care and adherence to evidence-based practice guidelines	Comment	Thank you for your comment. HCA will take this under advisement
We agree with the Children's Healthcare Improvement System plan from 2007 and think this is a useful starting document to implement improvements in our care of children in Washington State	Comment	Thank you for your comment. HCA will take this under advisement
We also are eager to share with you the outcomes of the CHIPRA grant that we are working on with Rita Mangione-Smith on the development and feasibility of pediatric quality measures for children with special health care needs. The WCAAP continues to strive for improving the quality of care delivered by pediatricians in our state. Pediatric practices will continue to provide accessible, continuous, coordinated, comprehensive, family-centered, compassionate and cultually effective care in local medical homes	Comment	Thank you for the services you provide to all children in Washington HCA. We appreciate the work of the Chapter.
Section 11.1.3. Editorial: The apparent intent of this section would be better expressed by rewriting it as follows: –The Contractor shall acknowledge in writing, within five (5) working days, receipt of each grievance that is made either orally or in writing, and of each appeal.‖	Comment	Thank you for your comment. HCA will take this under advisement
Section 11.5.2.2. We disagree with requiring the hearing request to be within 10 days in order to con-tinue coverage through the hearing decision. The initial -appeal‖ request within the applicable timeframe should suffice, as it does for a hearing requested to challenge a decision made by the Depart-ment itself. The Contract‘s interposing of an additional layer of procedure between the enrollee and a neutral decision maker should not result in imposing an additional short deadline for the enrollee to continue receiving services.	Comment	HCA does not agree.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 11.8.2.2. In the comment just above on 11.5.2.2., we advocate not including this requirement. But if such an additional deadline is imposed, it should be substantially longer than 10 days in order to avoid problems resulting from slow mail and computation issues resulting from weekends and holidays. Thirty (30) days from mailing would be more reasonable.	Comment	HCA does not agree.
Section 11.8.2.3. Although the legal considerations stated above regarding sections 11.5.2.2. and 11.8.2.2. may not as strictly apply, so short a time after mailing remains problematic for the same rea-sons. We recommend allowing fifteen (15) days from mailing.	Comment	HCA does not agree.
We assume that these missing sections are still under development. Is that the case? We request the opportunity to review drafts of these and any other materials as soon as they are available.	Comment	This information will not be available until the RFP is released.
Section 12.5. Transitional care. We would appreciate additional time to review this section.	Comment	There will be no additional time for review until the RFP is published. Thereafter questions and answers will be taken and answered as stated in the RFP.
Section 12.6.7 references special health needs defined in WAC 388-538-050. Special needs are broken into two areas: children (younger than 18) and adults. Children include those designated as having special healthcare needs by DOH and receive services under Title V, children eligible for Supplemental Security Income under TXVI of the Social Security Act, and children who are in foster care or who are served under subsidized adoption.	Comment	The contract distinguishes Children with Special Healthcare Needs.
Enrollees having chronic and disabling conditions and the conditions have: 1. biologic, psychologic, or cognitive basis, 2. have lasted or are virtually certain to last for at least a year, 3. produce one or more of the following conditions: significant limitation in areas of physical, cognitive, or emotional function, dependency on medical or assistive devices to minimize limitation of function, or in addition, for children, any of the following: significant limitation in social growth or development function, need for psychological, educational, medical, or related services over and above the usual for the child‘s age, or special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

We have developed a list of principles we feel need the HCA should incorporate into the RFP and Contract to improve the health of our communities while bending the healthcare cost curve. Our recommendations follow, listed in accordance with the attached principles: • The RFP and Contract lack specifics on person-centered health homes. The RFP and Contract should include specific information on these homes, including co-management of patients with co-morbidities and co-location of integrated services.	Comment	Thank you for your comment. HCA will take this under advisement
While the RFP and Contract require health plans to coordinate care with Regional Support Networks for mental health services, the description is vague and lacks any reference to substance use services. We recommend that the Contract require health plans to formalize contracts or Memos of Understanding with each County and Regional Support Network to identify the responsibilities and payment mechanisms to ensure adequate coordination and provision of mental health and substance abuse services. In addition, the RFP and Contract do not require plans to be accountable for psychiatric, crisis and involuntary commitment (ITA) services and to provide psychiatric hospitalization as necessary. We are concerned that without clear language, the plans could pass these responsibilities and costs onto local communities. We recommend that the RFP and Contract require health plans to care for patients using the National Council for Community Behavioral Healthcare Four Quadrant model; this includes collaborating with mental health and substance use providers to obtain psychiatric, crisis and involuntary commitment (ITA) services and psychiatric hospitalization as necessary. We also recommend	Comment	Thank you for your comment. HCA will take this under advisement
Although the RFP and Contract describe chronic care management services, the description is vague. We recommend that the RFP and Contract require health plans to adhere to the chronic care model as described in the literature by the Robert Wood Johnson Foundation at http://www.improvingchroniccare.org/index.php?p=The_Chr o nic_Care_Model&s=2.	Comment	Thank you for your comment. HCA will take this under advisement
The RFP and Contract do not mention any requirement that providers within plans and Accountable Care Organizations use a common, integrated electronic health record. This raises additional concerns about whether the plans will be able to measure and improve performance adequately. We recommend that the RFP and Contract require providers within health plans, through Accountable Care Organizations, use common, integrated electronic health records (EHRs). These providers would include primary care providers, specialty care providers, inpatient providers, mental health providers, substance use treatment providers and oral healthcare providers. We also recommend that EHRs used by different Accountable Care Organizations be able to communicate with each other.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

We recommend that the RFP and Contract include language that requires health plans to provide clinical preventive services as well as health promotion services	Comment	See response to line/question 81
1.24 Definition of chronic care management services should be revised to make clear the distinction between health home and community based health homes under 2703 of the Affordable Care Act. This becomes an issue when Medicaid population rolls into managed care and is served under this contract for their primary and acute care. Concern that if that distinction is not made there is an appearance of duplication if someone served by the HO contractor also receives an approved 2703 service due to targeted high needs.	Comment	Thank you for your comment. HCA will take this under advisement
*1.18 Consider revising definition of continuity of care to include transitions from skilled nursing to home or community based residential settings.	Comment	The definition will be modified.
*1.50 Integrated health homes – clarify to include functional abilities limited due to cognitive impairments (this would make sure that populations such as those with traumatic brain injury and limitations due to aging (dementia, etc.) are included.	Comment	Thank you for your comment. HCA will take this under advisement
*5.7.2 add or discharge from institutional care to the requirement under appointment standards.	Comment	Yes, we will add requirement.
*12.5 add DSHS Home and Community Services and Area Agencies on Aging to required operational agreements.	Comment	Thank you for your comment. HCA will take this under advisement
12.6.4 consider adding requirement to ensure enrollees at high risk of reinstitutionalization have a documented intervention plan to mitigate health risks.	Comment	Thank you for your comment. HCA will take this under advisement
12.6.5.8 add Area Agencies on Aging	Comment	Thank you for your comment. HCA will take this under advisement
12.6.6 add requirement of how to access long term care services to website and written resource materials.	Comment	Thank you for your comment. HCA will take this under advisement
12.7.3 should consider adding DSHS/Area Agencies on Aging to share information related to individuals with special health care served by our system	Comment	Thank you for your comment. HCA will take this under advisement
Local community partners, including local government and local public health, medical, mental health and substance use treatment providers have reviewed the RFP for Managed Care Services and the proposed Contract for Healthy Options, Basic Health and Disability Lifeline. We believe that the draft RFP and Contract as written will fail to meet the triple aim of improving the health of patient populations, enhancing the patient experience of care, including quality, access and reliability, and reducing or at least controlling the per capita cost of care.	Comment	There are many challenges as we move forward with this procurement, but HCA is committed to ensuring all of these important facets of healthcare are met.
Section 3.2.6 refers to the sharing of costs of producing materials that the HCA prints and publishes; can you provide a more specific description of what costs plans would be required to bear, and how those amounts would be calculated?	Communication and/or Materials	This information will not be available until the RFP is released.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Contract Section 3.26: States that -If the HCA produces the information to be provided to enrollees and potential enrollees, the Contractor agrees to pay a mutually agreed upon assessment once a year to reimburse the HCA for the Contractor's share of production and mailing costs.‖ Please provide confirmation regarding whether the Combined Handbook will continue to be distributed by the HCA or whether this may change. Please also provide information regarding the assessment of cost will be determined for new plans.	Communication and/or Materials	This information will not be available until the RFP is released.
Section 12.5.1.4.x requires notification to contractors/contract providers by RSNs and certain facilities. Will HCA assist in assuring cooperation from these entities? This will impose a requirement on plans, but we have no way of compelling facilities to do it. Section 12.5.1.1 references -an accepted, standardized…tool designated by the Health Care Authority…‖ Will HCA be developing a tool, process, and/or form(s) to be used by plan providers in meeting the requirements in this section and in 12.5.1.2?	Coordination of Care	We are working with our partners to facilitate common contract language. HCA will not be developing tools but rather designating tools.
Will there be outreach and marketing rules put in place to find clients?	Communication and/or Materials	Please review the marketing provisions of the Sample Contract.
Outreach, education, and enrollment activities need special design in order to be effective for homeless and other vulnerable populations, provisions that go well beyond the reading level of written materials. Outreach must precede enrollment into managed care and be an integral part of marketing and enrollment activities, and it needs to involve homeless service organizations in places where homeless people congregate. This will be especially critical if transitioning the SSI population to managed care, as was the case when GAU shifted to managed care. In 2004, Public Health-Seattle & King County and community-based agencies had to take quick action to help educate homeless people and case managers about the shift to managed care and how to avoid auto-assignment into a plan. Public Health was happy to support these efforts, but we also believe that more up-front planning and investment at the local level for these activities is needed. From our perspective, coordination with public health and community-based agencies was an afterthought. The Contractor should be proactive in coordinating with local partners, and help facilitate and fund	Communication and/or Materials	
10. Permit health plans to publish their own member handbooks.	Communication and/or Materials	Thank you for your input.
In reviewing the Draft RFP we are trying to locate the Encounter Data Transaction Guide published by the Health Care Authority. Can you provide the link or location of this guide for our review?	Contract/RFP	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

2) While the RFP refers to -Program Integrity‖ the contract makes no mention of this term. What is the definition of Program Integrity. Please define this term both in the RFP and the contract.	Contract/RFP	HCA will incorporate this definition into the final RFP
1. Procurement Schedule, the dates in item 10 through 12, also in Section 4. Contract the term dates may be off. There are also some issues with links not working, but this may be fixed as part of the final RFP document. I also note that the Sections are not consecutively numbered (i.e. A,B,C.E.D). The DRAFT contract template also had not had dates updated.	Contract/RFP	HCA will review this and make corrections when applicable.
What is meant by the –program subsections‖ referenced at the bottom of page 25/top of 26?	Contract/RFP	The "program subsections are the separate subjects, such as Quality Assurance and Performance Improvement, Thank you for bringing to our attention what may be confusing to a reader. The "program subsections" will be clearly labeled as such in the published RFP.
Also, one question with regard to the draft contract. Where/how does it define the scope of the benefit package that the contractor is responsible for providing? For example, how does the contractor know where its responsibilities for providing medically necessary services ends and ADSA‘s begins?	Contract/RFP	The benefits for the programs that are the subject of the procurement will be described in the specific contract exhibits for the programs. Those will be available when the RFP is published.
3. What is meant by the –program subsections‖ referenced at the bottom of page 25/top of 26?	Contract/RFP	The "program subsections are the separate subjects, such as Quality Assurance and Performance Improvement, Thank you for bringing to our attention what may be confusing to a reader. The "program subsections" will be clearly labeled as such in the published RFP.
Section 4.9.1 allows HCA to impose sanctions -up to 5% of the scheduled payments,‖ broadly referring to the Contractor‘s failure -…to meet one or more of its obligations under the terms of this Contract or other applicable law.‖ Section 4.9.1 does not more specifically describe what such failures may be. Section 4.9.2 does have a listing of causes for intermediate sanction (4.9.2.1 through 4.9.2.7); is this list a complete listing of possible reasons for sanctioning under 4.9.1? In general, we are interested in knowing the criteria or specific failures that HCA would use to differentiate a -sanctionable‖ shortcoming from one that would not rise to the level of a financial penalty. This section also refers to -cure‖ and –cure period,‖ but these terms are not included in the definitions section and don‘t seem to be discussed elsewhere in the draft contract. Can you more specifically define them?	Contract/RFP	We will review the requirement.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

There does not appear to a distinction in the draft Contract between the program requirements or health plan responsibilities for Healthy Options enrollees vs. Basic Health enrollees. Does HCA anticipate that these program requirements will require further differentiation in subsequent drafts of the contract (e.g. appeal rights, benefits, enrollment, etc.)?	Contract/RFP	There is a base contract and exhibits that describe specific program requirements. The base contract (what was provided) applies to all programs. The program specific exhibits were not provided and will not be available until the RFP is published.
Contract Section 7. Policies and Procedures: This section includes new language around -monitoring compliance with written policies and procedures‖ and that we will complete a -self-assessment of its policies and procedures‖. Please describe in more detail what this specific requirement means.	Contract/RFP	HCA believes that the requirement is clear. Plans must monitor staff and subcontractor compliance with policies and procedures and assess compliance with requirements every time a modification is made to a policy and procedure.
What are the key plan features (example, guaranteed issue, no cost sharing for preventative services)?	Contract/RFP	This information will not be available until the RFP is released.
The Sample Contract provided is a modified version of the current Healthy Options/SCHIP Contract, which contains provisions that Basic Health is not subject to currently. Will a separate sample Basic Health Contract be provided or is a bidder to consider that the BH Contract will be consistent with the HO/SCHIP contract, with the exception of covered services?	Contract/RFP	There is a base contract and exhibits that describe specific program requirements. The base contract (what was provided) applies to all programs. The program specific exhibits were not provided and will not be available until the RFP is published.
In reviewing the Health Care Authority Procurement for Managed Care Services RFP, we were not able to access the he web link listed in the RFP to download/view the Exhibits. Can HCA post the Exhibits on the HCA joint procurement website (http://www.hca.wa.gov/procurement.html.) ?	Contract/RFP	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published.
Section 7.3 of the draft Contract identifies that a self assessment must be submitted anytime there is a new policy and procedure or a change to an existing policy and procedure. Please confirm that this requirement applies only to key policies and procedures developed for specific contractual requirements such as grievances and appeals, and utilization management. If the requirement is broader, will HCA please provide a description of the scope of the policies and procedures that this requirement applies to?	Contract/RFP	Policies and procedures means any policy and procedure related to a contract requirement.
Per page 20, Section B, geographical analysis should -(d) Separate analyses for PCPs, Pharmacies, Hospitals, Obstetricians, ENTs, Mental Health Specialists, Cardiologists, Orthopedic Specialists and Neurologists.‖ a. Will the state clarify access standards to use for these separate analyses in terms of mileage? b. Please confirm/clarify the category of Mental Health Specialists is limited ONLY to actual persons and does not include Outpatient or Inpatient Facilities as a provider of record.	Contract/RFP	Standards will be clarified.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 3.2.5.13 of the draft Contract identifies that health plans must notify enrollees of their -conversion rights under RCW 48.46.450 or RCW 48.44.370.‖ Please confirm that for MCOs that do not offer any commercial products, and therefore do not have a commercial individual insurance policy to offer a member who loses eligibility, this requirement is not applicable.	Contract/RFP	Confirmed.
Section 1.49.6 mentions -Individual and family support including authorized representatives‖; can you characterize what –support‖ means in this context, and can you define -authorized representative‖?	Contract/RFP	Support means the enrollees support. Family includes biological family. Authorized representative means individuals authorized by the enrollee.
The language in Section 3.2 that –either the HCA or the Contractor‖ shall provide information could lead to a lack of clarity—and the -if‖ statements that accompany these requirements cite only the Contractor as the party to address failures or contingencies (which could mean that they would be correcting an oversight or error originating with HCA). Can you clarify your expectations in this regard?	Contract/RFP	We will review this section for the published RFP.
Section 6.4.1 mentions -validation procedures‖ to be used in each specific area listed under 6.4.2; can HCA provide more detailed information on those procedures?	Contract/RFP	
For Section 6.7, can you provide more detail on the criteria and process by which formularies are reviewed and approved, with specific reference to how potential disapprovals are addressed?	Contract/RFP	The formularies are reviewed to assure sufficiency for each therapeutic class. We work with plans until there is an approved formulary, so disapproval is not an issue.
Contract Section 8.7 Excluded Individuals and Entities: This language appears to be the same as in the current agreement. We had heard at a recent Healthy Options All Plan meeting that this language was going to be revised based on more recent guidance by CMS that would eliminate some of the requirements. Please provide us with any changes or updates to this language.	Contract/RFP	The language will be revised in the published RFP.
Are these definitions based on any standardized best practices definitions? We believe they should be and should be referenced in the contract (i.e., NCQA, AMA, etc.). This will prevent conflict between what HCA, CMS, NCQA, etc. require for reporting etc. Is the definition of Integrated Healthcare Home inclusive of the definition of Health Home? In other words, is the Integrated Healthcare Home definition building on top of the Health Home definition? If so, this would be problematic because Health Homes are PCP driven, and the care required for Integrated Healthcare Homes may require specialists instead of PCPs.	Contract/RFP	We will review and clarify if necessary.
Is the intent that the RFP Draft and Contract Draft are considered together when looking at requirements?	Contract/RFP	Yes, they should be considered together

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

This section states the ‐five‖ major sections shall include: Administrative Requirements, Program Requirements and Rate Requirements. Are there other sections that will be added or should the ‐five‖ be revised to ‐three‖?	Contract/RFP	We will review this section when the contract is complete.
Contract scope: potential enrollees, both as currently drafted for Basic Health and Healthy Options enrollees, and as envisioned during the term of the contract? Are there specific plans to expand the scope before the end of 2013? It is our understanding the budget assumes this will occur. What are the implications of adding Supplemental Security Income, Disability Lifeline and other programs to the contract?	Contract/RFP	There is a base contract and exhibits that describe specific program requirements. The base contract (what was provided) applies to all programs. The program specific exhibits were not provided and will not be available until the RFP is published.
First, we have some general comments. We noticed that critical sections are missing from the draft contract. The Enrollment section (section 4 in the current Healthy Options contract) is completely omitted. Without this section, we cannot tell which eligibility groups are intended to be covered by this contract. In particular, SSI-related Medicaid and Medical Care Services have not previously been included in this contract. Because these groups have needs that may not be sufficiently addressed under the existing Healthy Options/Basic Health model, it is essential to know how contracting is intended to be handled. For example, to our knowledge, the Primary Care Case Management model (the very model that DSHS first used when the Department previously sought to implement Healthy Options for SSI recipients beginning with Clark County during 1995-96) has not been considered for the SSI population. We think it is important to fully understand and evaluate this model before assuming that SSI clients are best served through Healthy Options. Similarly, Medical Care Services is currently handled	Contract/RFP	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Here are some corrections that I see are needed in the current draft: Section 1.45 Health Care Professionals – include ‐registered dietitians‖ Section 1.49 Health Homes – say ‐also known as medical homes‖ Section 1.50 Integrated Health Home - say ‐also known as integrated medical home‖ Section 2.4 Compliance – add –Individuals with Disabilities Education Act (IDEA) of 2004‖ Section 5.6.1 Customer Service – does this have to be provided in alternate languages if >5% of the clients speak something other than English? Section 12.6.5.5 ITEIP needs to be updated to ‐Early Support for Infants and Toddlers (ESIT) Sections 3.3.2.3, 4.9.2, 5.9.2, 6.4.4.3, 8.8, 8.11.1.3 – all have a typo with the word ‐the‖ before ‐Health Care Authority‖. ‐The‖ should be capitalized at the start of these sections and often also at the start of sentences within these sections. I suggest you do a word search for ‐the Health Care Authority‖ to find all the instances when a capital ‐T‖ has been omitted throughout the draft.	Section Numbers, spelling, etc.	We will incorporated the appropriate corrections into the final RFP. Thank you.
While the RFP and Contract describe coordination of care, they do not address accountability for this coordination or outcomes. We recommend that each health home would have to be part of an Accountable Care Organization that ensures appropriate and timely access to specialty care, inpatient medical care, substance abuse treatment, including outpatient and inpatient substance abuse treatment, and long-term care. In addition, to ensure that plans are providing integrated, coordinated care, we recommend that the RFP and Contract require plans to collaborate with other funding sources, included, but not limited to, insurance, state and federal grant funding, county government, tribal government and Regional Support Networks.	Comment	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 12.6 The contract at 12.6 Coordination of Care does not identify local affordable housing systems or local homeless systems. Many local housing plans address the need for supportive housing for low-income households, the homeless, and those with mental health and/or substance abuse issues. Many of the chronic homeless also have these issues that keep them on the streets until they can be re-housed with the necessary supportive services.	Comment	Thank you for your comment. HCA will take this under advisement
Potential Opportunity: Overall, the two sections (12.5 & 12.6) of the contract emphasize the need for better coordination of transitional care and ongoing coordination between MCO and County programs to promote quality of care for enrollees. This requirement is in alignment with the current published Global Medicaid Modernization Initiative/WA Healthcare Reform. However, there is a need for HCA to assess the financial implications of care coordination efforts between MCO and County programs. For example, MCO will have free access to PRISM database for care coordination effort, but County programs may need to pay in order to get access to this database for the same purpose.	Comment	The HCA will take this into consideration.
It is important to note that conflicts may arise between the MCO awarded this contract and those providing service and determining the medical necessity. With the incentive payment segment of the contract acknowledging that it may result in limited service, medical necessity may be determined by cost rather than patient need.	County	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 12.5.1 requires operational agreements which include data sharing for the purpose of facilitating transitions of care and delineates in the following sections the responsibilities of the contractor, the managed care organization awarded the contract, and call out specific tasks that must be done such as completion of a pre-institutional, pre-hospital, and pre-substance abuse disorder treatment discharge screening tool (12.5.1.1), interventions to mitigate risk of re-institutionalization, re-hospitalization and recidivism and require admission into outpatient MH services within 48-hours (12.5.1.2). • The issue here is how much additional work the screenings require of the county programs and will the county have any control over the extent of these screenings. • Access within 48-hours will be a challenge for all county programs, especially A&D which has had deep cuts and DD since access is arranged by DDD. • The document is not clear about roles, that is, contractor functions vs. county program functions. It looks like it could all be pushed down to the county programs. • Because it is not clear about roles, there are also questions about financial responsibility. • The contract needs clarity on who will be qualified enrollees under this contract, and for whom will be counties be responsible for treatment services? If there are stages of	County	Thank you for your comment.
The remaining sections of 12.5 have to do with reporting to the contractor and primary care provider upon admission or discharge from a RSN/A&D, etc., facility. • No major concern with these areas unless reporting requirements are beyond the current standard of practice. The scope of this work by the county providers needs to be identified and/or language added concerning negotiating with county programs.	County	Thank you for your comment.
Section 12.6 delineates contractor‘s tasks associated with coordination of care and requires the contractor to coordinate and ensure PCPs coordinate with community based and DSHS services. There is a list provided of services including RSN and A&D. • This section does not impact county programs significantly as it relates to coordination with the PCP, yet it seems it will require county programs to make reports. Again, the scope of this work at the county level needs to be identified or at least have language about negotiating with county programs. Section 12.6 focuses on coordination of care and the contractor‘s role.	County	Thank you for your comment.
The word -completed‖ in this section of the current HO contract is changed to -all‖. Please describe how or if this change impacts the way we currently report DAG information.	DAG	The use of the term all more accurately reflects the HCA's intent to be informed about the total universe of grievances, actions and appeals, not just those completed.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 11. Grievance and Appeal. Some of these provisions may be affected by the implementation of the Affordable Care Act at the federal and state levels. This should be acknowledged in the contract so it can be adapted to new requirements. We would also appreciate the opportunity to review and com-ment further on this aspect of the contract. The contract reference the "HCA Board of Appeals" in 11.7., 11.8.2, 11.8.2.2.4, 11.9.1. No such Board of Appeals currently exists. Perhaps this was drafted in anticipation of HCA establishing such a Board; we would appreciate your consideration of this.	DAG	There will be no additional time for review until the RFP is published. Thereafter questions and answers will be taken and answered as stated in the RFP. Thank you for your input., we will review these contract sections.
Section 6.3.9 relates to data on ethnicity, race, and language; can you describe what information the state collects and can provide, based on its intake processes?	Data	The HCA collects information on race, ethnicity and language from all individuals applying for Medicaid benefits. This information is then passed through to the MCOs monthly. A Best Practice among MCOs is to maintain two separate fields for race, ethnicity and language data. One set that is used to populate data received from the HCA. A second set is used to populate data received from MCO operations (e.g., through Call Centers; Care Management, Utilization Management, etc.). Having two separate fields allows the plan to enhance the data collected from the HCA and to conduct sub-analysis of data to identify disparities in health care services based on race, ethnicity or language.
The term of the initial contract is stated as February 1, 2011 through December 31, 2012. Are these dates correct?	Dates	The initial term of the contract is February 1,2012 through December 31, 2013
Section 4. Contract (page 10) of the draft RFP states that the "term of the intial Contract will be from February 1, 2011 through December 31, 2012". We assume there is an error with the dates and the initial term of the contract is February 1,2012 through December 31, 2013 .	Dates	The initial term of the contract is February 1,2012 through December 31, 2013
The cover page of the draft Request for Proposal (RFP) indicates an estimated contract period of July 1, through December 31, 2013. However, Section B.4 of the RFP identifies a contract period of February 1, 2011 through December 31, 2012. Please confirm which of these contract periods is correct.	Dates	The initial term of the contract is February 1,2012 through December 31, 2013
Do you still expect to release the RFP in July 2011?	Dates	Yes. The HCA plans to release the RFP in July 2011.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

There is inconsistency within this section: For termination, suspension, or reduction of previously authorized services, five (5) business days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within this ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days. The current Healthy Options contract calls out 10 calendar days for both. Is the intention for both figures to be 5 business days, or 10 calendar days?	Dates	We will change 10.2.4.2. as follows: For termination, suspension, or reduction of previously authorized services, five (5) business days prior to such termination, suspension, or reduction, except if the criteria HCAd in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within this five (5) business day period by a method that certifies receipt and assures delivery within three (3) calendar days.
Please clarify proposal due date and time?	Dates	The date/time will be in the published RFP.
8. Confirm the final submission date for RFP responses. It is listed as October 17, 2011 and October 28, 2011.	Dates	The date/time will be in the published RFP.
What is the eligibility criteria?	Eligibility	This information will not be available until the RFP is released.
Can the carrier set a membership cap?	Enrollment Cap	No
All sections request a comprehensive Implementation and Operations Plan that addresses all requirements of the specific identified section, or in the case of Section G all requirements not identified separately in other sections. Can the HCA provide further details be provided as to what the reviewers will be looking for to satisfy this section? Is the HCA seeking a narrative response? Gant charts, a combination of both or something different entirely.	Evaluation	Will clarify how to respond to this subsection in the published RFP.
7. Provide a list of the RFP response reviewers and their qualifications, as well as any oversight committee members.	Evaluation	No
Topic: Evaluation On Page 25, in Section D. Evaluation. Please provide further clarification about the scoring methodology. Pass/Fail scoring can be somewhat ambiguous. When you state that a contractor will receive a pass/fail score -if a contractor does not provide required information‖ how will that be determined? Many of the RFP elements include submission of written documents that describe a comprehensive plan of operations to meet certain requirements. Does the Pass/Fail scoring relate to providing the documents requested in the RFP response or the detail submitted? Who will be on the evaluation team? Please describe the consensus scoring methodology in more detail.	Evaluation	The will RFP provide sufficient information to prepare a response. The scoring will be described in necessary detail. We will not provide criteria beyond the RFP and Sample Contract, as those are the criteria, We also will not be providing evaluators names or how they will reach consensus.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

For Binder 3 7, each of these specifications requests responses -…in a manner that allows evaluators to be assured that the Bidder understands the requirements and is fully capable of implementing those requirements.‖ We understand the intent of this language, but would like to know more about the criteria or decision rules that evaluators will use to –be assured,‖ particularly when bidder responses may vary significantly from one another. There is always some element of subjectivity in comparing submissions, but we think HCA and bidders share a mutual interest in minimizing subjectivity and maximizing the use of concrete, objective methods of comparing different proposals	Evaluation	Thank you for your input. Proposals will be objectively evaluated on how well they address the requirements stated in the RFP and Sample Contract by expert evaluators. The burden of preparing a competent response is on the Bidders. The Sample Contract and RFP are the criteria.
Will WBH be evaluated under same standards as Medicaid?	Evaluation	Yes
11. Please confirm that existing health plans are not required to supply documentation for an element when the section reads, –Evaluators will have past monitoring reports for Washington for evaluation.‖	Evaluation	Current contractor will not need to provide HCA (MPA) monitoring results.
Bid Evaluation - Is there a price component to the plan bid evaluation that the state will look at? If so – how much of the state's evaluation would be weighted towards the price component of the bid? - Is there a way to see which Medicaid Managed Care plans bid during Washington's last RFP procurement?	Evaluation	Yes, there will be a price component. Evaluation will be further described in the published RFP. Prior bids are not available.
Can you possible e-mail me Exhibit D, the Web link is not responding.	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
1. When/where will the –Exhibit D – Information regarding the population to be served‖ info be available?	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
RFP Draft Exhibits don't seem to line up with the Table of Contents. Please clarify.	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
Contract Section 6.4.4.1: Includes language regarding CAHPS®. Please provide further clarification regarding a contractor's requirement to administer a CAHPS® survey.	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
Please provide Exhibit B with the RFP detailing the services covered for BH enrollees.	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
What about Coordination of Benefits (COB)?	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Will HCA please provide a copy of Exhibits A through D to the draft RFP? The link provided within the document does not work.	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
Can you please provide clarity around the specific claims payment dispute requirements?	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
Can you please provide clarity around the specific TPL/COB requirements?	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
Can you please provide clarity around the regulatory reporting requirements (e.g. Claims TAT, TPL/COB)?	Exhibits	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published in July 2011.
Section 5.3.1 mentions fee for service (FFS) access as the comparator for a plan‘s timeliness. Can HCA provide data that reflects current FFS timeliness of access for our use?	FFS	We will modify this to be more in alignment with the Federal requirements in the Sample Contract included with the published RFP.
Sections 11.2.1, 11.5.1. This section states that a provider may not request a hearing on behalf of an enrollee. Is there any reason an enrollee should not be able to choose a provider as his or her repre-tative? We request that you add "unless the enrollee authorizes."	Hearings	Thank you for your comments; the language will remain as stated.
14. Please remove or define the bullet under the quality section that refers to -Developmental Screening‖ as it is not a HEDIS measure	Performance Measures	NCQA is in process of adding Developmental screening as a HEDIS measure. You are correct in that it currently is not a HEDIS measure.
The following sections from the current Healthy Options contract are excluded from the draft contract: o Enrollment o Rates/Premiums o Delivery Case Rate o Recoupments o Hemophiliac Stop Loss o Payments to Critical Access Hospitals – will this be updated to the new Hospital Safety Net Assessment language? o Assignment of Enrollees o Stated Capacity & Capacity Increases/Decreases o Benefits (to include Enrollee Hospitalized at Enrollment and Coordination of Benefits, Subrogation of Rights of Third Party Liability & Contracted Services) o Exclusions o Enrollee self referral Will these sections be included in the final contract? If not, please explain the reasons for removal of these sections.	HO	The full Sample Contract will be available when the RFP is published.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 10.1.6.2. This statement permitting the contractor to follow HTAC recommendations -where appropriate‖ is improper. Contractors should be required to follow WAC 388-501-0055, which requires to evaluate whether an HTA decision should result in non-coverage as a Medicaid services. Most im-portantly, Medicaid law may supersede an HTA exclusion. The Health Care Authority should specify in regulation any decision relating to noncoverage.	HTA	Thank you for your comment. HCA will take this under advisement
To participate in the State program each provider must have a Medicaid ID number. Will a listing of the state assigned Medicaid numbers be available in the near future?	ID numbers	A provider does not need to contract with HCA to be a managed care provider.
In order to be consistent with Healthcare Reform we suggest HCA use the NAIC definition for Medical Loss Ratio instead of the OIC definition referenced in 4.2 of the contract. http://www.naic.org/documents/index_health_reform_mlr_blanks_proposal.pdf	Medical Loss Ratio	Thank you for your comment. HCA will take this under advisement
Medical Loss Ratio Limitation - In the 2012-2013 Contract that was released, in section 4.2 it notes a MLR limitation of at least 83% for plans. How is this ratio calculated with regard to adjusting either the numerator or denominator of the ratio calculation (for example, if state premium taxes are excluded from the calculation perhaps)? - Is this 83% MLR limitation an apples-to-apples comparison to the 80% MLR limitation that was noted in the 2008-2011 Contract in section 6.2?	Medical Loss Ratio	We will clarify the medical loss ratio provisions of the Sample Contract.
24.Section 4.2 identifies that the medical loss ratio requirement of 83% will be in effect for calendar years 2009 and 2010. Please confirm that this is a typo and should be calendar years 2012 and 2013.	Medical Loss Ratio	We will clarify the medical loss ratio provisions of the Sample Contract.
Section 4.2 identifies that the -Contractor medical loss ratio for each program is limited to 83% in each calendar year.‖ Please confirm that HCA intends to calculate medical loss ratio separately for each of the proposed programs (e.g. Healthy Options, Basic Health, and Disability Lifeline)?	Medical Loss Ratio	We will clarify the medical loss ratio provisions of the Sample Contract.
30.In Section 4.2, the way in which MLR is to be calculated isn‘t clear from this section; can you provide a pro forma or explicit formula that describes it? We would particularly like to know how quality incentive payments to providers are to be factored in. We also question the inclusion of the Delivery Case Rate in the -multiplier‖ part of the overall calculation; this is a pass through amount that does not constitute a risk based payment to plans. We note that this section mentions two contract years (2009 and 2010) that are not included in the term of the contracts that will be entered into as a result of this procurement.	Medical Loss Ratio	We will clarify the medical loss ratio provisions of the Sample Contract.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Contract Section 4.2 Medical Loss Ratio: Includes a change from the current limitation on MLR of 80%, to 83%. At the same time that the MLR limitation is increasing, we are experiencing additional administrative cost, such as with the High Risk Pool assessment which has consistently been increasing over the last couple of years, as well as additional administrative expense to support changes to our encounter reporting, HIPPA and ICD 10 compliance resulting in additional IT infrastructure and programming, and expense related to additional Quality and HEDIS measurements requirements or more robust coordination efforts in the new contract. In addition with new populations, there may be a lot more fluctuation with trends and utilization results and trying to target to a specific MLR ratio and more need to have premium revenue earnings from year to year to support these shifts. Has there been any consideration to that issue in setting the MLR?	Medical Loss Ratio	Thank you for your input.
Section 4.2. The draft contract requires a Medical Loss Ratio of 83% - we would like to understand how this number was chosen and how this would need to change as the ACA is implemented. The Basic Health Option would require plans to have a minimum 85% Medical Loss Ratio.	Medical Loss Ratio	Thank you for your input.
Please clarify whether it is the health plan or the provider who completes the assessments, planning and interventions referred to in these sections. Per 12.5.1.2 all members are required to receive scheduled mental health or primary care follow up visits within 48 hours of discharge. Not all members require follow up visits within 48 hours of discharge. We suggest the requirement be changed to -if medically indicated‖. Will RSN and other contracts with HCA/DSHS include the same 48-hour coordination of care requirement as the Healthy Options plans? If plans do not receive timely notice regarding discharge from the RSN or CD providers it will be difficult or impossible to meet the 48-hour care coordination requirement.	Mental Health	The contractor is responsible for all performance under the contract.
Will RSN and other contracts with HCA/DSHS include the same 48-hour coordination of care requirement as the Healthy Options plans? If plans do not receive timely notice regarding discharge from the RSN or CD providers it will be difficult or impossible to meet the 48-hour care coordination requirement.	Mental Health	Thank for your input. We are working with our partners to have reciprocal requirements.
Regarding the QAPI and PIP programs – does the state define the metrics for both of these programs? If so, it would be helpful if the State were to define and communicate the intended metrics to plans in the RFP.	Performance Measures	The metrics for QAPI are the HEDIS measures; the metrics for PIPs are up to the MCOs, except where the focus of the PIPS are called out in contract.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Community Health Plan of WA, Molina, and Regence are already contracted Managed Care Contractors in the State of Washington. I am just curious as to why the State is asking for more Bidders? Is the State not happy with results from the current contractors?	Miscellaneous	HCA views this procurement as the mechanism to prepare the State to fulfill its obligations under the federal Patient Protection and Affordable Care Act. Under the Act, as many as 400,000 state residents who are currently ineligible for Medicaid will become eligible. To meet its obligations under the Act, the State must have systems, provider networks, and processes in place.
Additionally, it would be helpful to have a better understanding of HCA's intentions beyond 2013 and whether or not the state plans to extend the current contracts that are awarded. For new Medicaid plans that may be devoting significant development and implementation costs, this information would be helpful in further evaluating this opportunity	Miscellaneous	HCA's has been working on reviewing our intentions for health care beyond 2013. When this project is complete, we will share this. The contracts will allow for extension.
Enrollee is defined as an -individual enrolled in HO managed care‖. Will this be refined in the RFP to include enrollees in other programs like BH and SSI?	Miscellaneous	Populations will be clearly defined in the published RFP
Could you comment on the possible ways in which HCA‘s two programs (HO/BHP) and the single 2012-2013 contract with carriers will relate to the statewide exchange(s) once the latter are established? Will your contracting health plans be required to participate in the exchange, or will the two programs in any way integrate with (and thereby impose requirements on) each other?	Miscellaneous	This question will be settled at the legislative level.
Our pharmacy, Premier Kids Care, Inc., is interested in submitting for the request for proposal for State-Purchased Health Care Programs. Do we need to do anything else at this time?	Miscellaneous	This RFP is for managed care organizations only. This RFP is not to contract with providers.
We received this email regarding subject RFP. We are in the process of becoming a provider for Washington State Medicaid (application and supporting documents have been sent). Is there anything additional we need to submit for the Healthy Options and Basic Health Programs or are they all inclusive once we are contracted?	Miscellaneous	This RFP is not with providers. This RFP is for health plans only. For information on becoming a provider with either Health Options or Basic Health programs, you would have to contact either Medicaid or the plans that contract with Basic Health and/or Health Options(Group Health Cooperative, Regence Blue Shield, Asuris, Community Health Plan, Columbia United Providers, Kaiser, and Molina).
I wanted to confirm that this RFP applies to managed care organizations, and not to service providers.	Miscellaneous	Yes, the RFP only applies to managed care organizations
Does HCA have a template -operational agreement‖ that can be shared with contracted plans? This would help facilitate timely implementation of this new requirement.	Miscellaneous	We will consider the request.
Section 5.6.1 . We would appreciate an explanation of the last two sentences.	Miscellaneous	We will review for clarity.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Network adequacy: and specialists, especially if the contract is expanded to include some of the disabled clients. What types of assurances are in place to make sure there will be access to sufficient specialty services?	Network/Service Area	HCA is committed to ensure network adequacy. We will have provisions in place within the contract that will ensure adherence to network adequacy standards.
Has there been any decision on what would the requirement will be for showing network adequacy? I know there had been a back and forth between LOI's and contracts.	Network/Service Area	Information regarding network adequacy will be addressed when the RFP is released
Section 5.10 ff. In evaluating network adequacy, we think it is very important to understand providers' actual availability, and not just the number of providers contracted. If the SSI population is intended to be included, much more needs to be done to beef up distance standards and ratios for specialty care.	Network/Service Area	Thank you for your comment. HCA will take this under advisement
To ensure continuity of care, will HCA be providing interested vendors with information on high volume (i.e., expenditures and utilization) Medicaid providers by beneficiary aid code to facilitate network development efforts?	Network/Service Area	This information will not be available until the RFP is released.
In examining provider access what criteria are you considering?	Network/Service Area	This information will not be available until the RFP is released.
Section 4.7 refers to -any‖ provider not having a contract with the Contractor; can you confirm that out of state providers are included in this payment policy?	Network/Service Area	This will be revised in the Sample Contract. The revision will be available when the RFP is published.
1) The RFP in Section 7 only defines -Service Area‖ as that which is -…..identified by HCA for separate bid‖. This definition provides no information. What will be the service area definition? It would be our preference that the –Service Area‖ be defined by 5 digit zip codes as is currently allowed under our Healthy Options contract. If the decision is to define service area by county, then it would be our recommendation that a plan is considered a current provider in that county for purposes of the other requirements in the RFP, even if it is currently only in parts of the county. Lastly, we would propose that the RFP allow for plans to state and set enrollment caps for any given service area by the different rate groups (HO, BHP, DL)	Network/Service Area	This information regarding service areas will not be available until the RFP is released. HCA does not intend to allow enrollment caps or partial service areas.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 10.2. We have a number of concerns about the requirements regarding notices to clients. 10.2.1. The statement of laws with which authorizations must comply is not broad enough. Regard-ing notice, compliance should also be required with portions of WAC 388-458 and 388-501, as elaborated below. 10.2.3.2. This does not, but should, address termination, suspension, or reduction of services (see 10.2.4.2) previously provided, whether or not those services have previously been expressly prior authorized. 10.2.3.2.2. In order to hold contractors to the same notice standards as the Department itself, which is required to give the -specific factual basis‖ for a denial of a service all or in part, WAC 388-501-0165(8)(b), this provision should read: -The reasons for the action, including facts specific to the enrollee, in easily understood language.‖ 10.2.3.2.5. Editorial: -the‖ should not be repeated at the beginning of the third line. 10.2.4.2. In the first sentence, 10 days rather than five (5) was probably intended, and should be required; the five-day period is provided in 42 CFR 431.214 only in cases of fraud. 10.2.4.2.2.3.1. To hold contractors to the same notice standards as the Department itself, this provision should read -By the fourteenth (14th) day following receipt of the request, mail the enrollee and the provider written notice…‖ See WAC 388-501-0165(7) (c).	Notices	Thank you for your comment. HCA will take this under advisement. Responses are as follows: 10.2.1. The content of the Contract relates to utilization management decisions, not those related to receiving Medicaid/DSHS benefits in general. The contract language will remain as written. 10.2.3.2. You are correct. 10.2.3.2.2. 'Specific factual basis' relates to the rationale for the authorization decision. This includes clinical information, often promulgated through HCA or nationally recognized evidence-based or clinical decision-making criteria used by the MCO for authorization decisions. The specific factual basis for the decision employs these criteria. These criteria are applied based on individual client needs. The HCA monitors the health plans for application of the criteria and consideration of individual client needs in decision-making. 10.2.3.2.5. We will take this change under advisement. 10.2.4.2. See response to line/question 174. 10.2.4.2.2.3.1. The HCA applies a combination of Washington HCA Patient Bill of Rights (PBOR) and Federal Centers for Medicare/Medicaid Balanced Budget Act (BBA) regulations to its managed care
Does the State plan on conducting outreach and education on the upcoming joint procurement to key stakeholders (i.e., providers, community based organizations, advocacy organizations, etc.) that interface with the target population for the joint Healthy Options/Basic Health programs prior to and once the RFP is released? In our experience, this can be very helpful in garnering stakeholder support and buy-in of the proposed changes to the Healthy Options program (i.e. mandatory enrollment of ABDs, etc.) and ensure a successful implementation	Communication and/or Materials	HCA and MPA staff work in partnership statewide community partners, Basic Health sponsors, providers, and key stakeholders to keep them informed of program information throughout the year. Healthy Options and Basic Health staff attend monthly and quarterly forums to keep advocates, community based organizations, and health departments informed of
If the state includes a premium withhold, please specify the performance metrics, amounts and timing to recover the withhold.	Performance Measures	We do not intend a premium withhold.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Contract Section 6.3: Includes many new or additional requirements for HEDIS® and non- HEDIS® measures. Many of the non-HEDIS® measures will be challenging to report and will require more costly chart extracts to try to capture this data. How will these non-HEDIS® requirements be measured or scored? Please define what Medication Possession Ratios are. Many of these measures are not even code specific, such as 6.3.4.3 Weight assessment and counseling for nutrition and physical activity for children and adolescents or 6.3.4.6 Developmental screening, which are both documented as part of an EPSDT exam. Please note that HEDIS® is defined as -Healthcare Effectiveness Data and Information Set‖ and not –Health Employer‖ as stated in Section 6.3.7	Performance Measures	Thank you for your feedback. We have modified the language in Contract for HEDIS reporting. The HCA will provide the MCOs with instructions for how to calculate the non-HEDIS measures prior to the required reporting period.
6.3.4.6 Developmental Screening – It is our understanding no such HEDIS measure exists. 6.3.4.12 Plan All Cause Readmissions – This measure is designated in the HEDIS specifications as applicable to the Commercial and Medicare lines of business only. It is not audited or reported for Medicaid. 6.3.4.19 Medication Reconciliation Post-Discharge – This measure is designated in the HEDIS specifications as applicable to Medicare SNP lines of business only. It is not audited or reported for Medicaid. 6.3.4.21 through 6.3.4.23 – -Non-HEDIS‖ measures. Does HCA have specifications available for these measures (as referenced in 6.3.2)? We would like to know the nature of the intended measures.	Performance Measures	Thank you for your feedback. While we appreciate the NCQA specifications for reporting purposes, the HCA is under no obligation to follow the specifications as written by NCQA. The HCA is responsible for clearly communicating the requirements and will attempt to do so in the next Contract iteration. The Developmental Screening measure is under development by NCQA. The Plan All Cause Readmission and Medication Reconciliation Post-Discharge measures are added and intended to reflect a potential expanded Medicaid population during this and future Contract windows. The HCA intends to require production of these measures for the Medicaid population.
Contract Section 6.3.4.12 Plan All Cause Readmission measure is a Medicare measure. Does the State intend to use this measure for Medicaid and Medicare? Please clarify.	Performance Measures	Thank you for your feedback. While we appreciate the NCQA specifications for reporting purposes, the HCA is under no obligation to follow the specifications as written by NCQA. The HCA is responsible for clearly communicating the requirements and will attempt to do so in the next Contract iteration. The Developmental Screening measure is under development by NCQA. The Plan All Cause Readmission and Medication Reconciliation Post-Discharge measures are added and intended to reflect a potential expanded Medicaid population during this and future Contract windows. The HCA intends to require production of these measures for the Medicaid population.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Contract Section 6.3.4.19 Medication Reconciliation Post discharge measure is a Medicare SNP measure that involves a hybrid collection method. Does the State intend to use this measure for Medicaid and Medicare? Please clarify.	Performance Measures	Thank you for your feedback. While we appreciate the NCQA specifications for reporting purposes, the HCA is under no obligation to follow the specifications as written by NCQA. The HCA is responsible for clearly communicating the requirements and will attempt to do so in the next Contract iteration. The Developmental Screening measure is under development by NCQA. The Plan All Cause Readmission and Medication Reconciliation Post-Discharge measures are added and intended to reflect a potential expanded Medicaid population during this and future Contract windows. The HCA intends to require production of these measures for the Medicaid population.
The quality and performance metrics in the RFP relate to health plan performance. We believe there also may be benefit to providing gain sharing opportunities in a consistent manner across all managed care plans to provide additional resources at the provider level for performance improvement. For example, will hospitals that score well on the new Medicaid quality incentive program also receive an increase in payment from the managed care plans? What provisions are there to encourage both plans and providers to move away from more traditional fee-for-service payment models?	Performance Measures	The HCA will take this under advisement.
QUALITY: One of the HEDIS quality measures is -preventable non-emergent emergency room rates‖ -- in the RFP, please include a list of codes to define non-emergent emergency visits	Performance Measures	The HCA will provide further direction on reporting of non-HEDIS measures including preventable non-emergency room rates outside of the RFP/contracting process.
12. Please clarify that -HEDIS rates‖ refers to audited rates from the previous year.	Performance Measures	Yes, this is correct, audited rates from the previous year.
Section 6.2 requires plans to conduct targeted improvement projects based on their experience and on data reflecting the plan‘s well child care. Are contractors new to Healthy Options required to have PIPs in place immediately, or would these be required later, based on developing experience?	PIP	New MCOs would be required to develop a plan for implementing the well-child PIP in the latter half of 2012 and report on the plan in 2013 using the standardized Performance Improvement Project Implementation Worksheet contained in the Federal PIP Implementation Protocol (See http://www.cms.gov/medicaidchipqualprac/07_tools_tips_and_protocols.asp?). The HCA would require completion of Activity 1 through Activity 7 sections (planning elements only) and report to the HCA in 2013.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Contract Section 6.2 Performance Improvement Projects: We note that the current contract section 8.2.6 has been eliminated. Just to clarify, there appears to be no requirements related to any additional performance improvement projects if a contractor‘s Combination 2, Childhood Immunization rates are below a certain benchmark.	PIP	You are correct, the PIP for immunizations has been eliminated. The HCA will continue to monitor the performance of the HEDIS childhood immunization measure with an expected goal of achieving the Healthy People 2020 goal of 80% coverage for the HEDIS Combination 2 sub measure and trended improvement in all other Combination sub measures over time.
Contract Section 6.2.6: Requires that Contractors conduct one statewide PIP on Transitional Healthcare Services. We are unclear about what this requirement specifically means. It appears to require significant involvement in terms of staffing resources and –potential funding‖ so we would appreciate more specific details about this requirement in order to assess the impact.	PIP	The HCA is sending a strong message to all contracted MCOs that they must collaborate on improving the quality of health care services to Medicaid enrollees. Many other HCAs have all MCO consortiums/organizations established to implement HCA wide performance improvement projects. It will be up to the MCOs, through collaboration and teamwork to define the scope of this project to arrive at improved transitions implemented to reduce 1) re-hospitalizations and 2) promote appropriate medication management post-discharge or transitions between settings (e.g., hospital to nursing home). There is a body of literature that can be tapped to help the plans collectively design and implement a transitions performance improvement project.
Contract Section 6.2.7.5: Appears to increase financial support for the EQRO annual PIP by about $20,000. Please provide more detail regarding why this cost has substantially increased. Please describe what specific value or benefit this provides to us as a contractor.	PIP	The cost has substantially increased because Medicaid enrollment has expanded and the need for redesign of primary care to arrive at efficiency and quality-based medical or health homes is fundamental to health care reform.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

6.2.6.1 This section references hiring a leader to manage the statewide PIP. Is this included in the contractor financial support outlined in 6.2.7.5 or is this in addition to that financial support? While the draft clearly indicates the desired topic and methods to be included in this Performance Improvement Project, the specific plan responsibilities versus collaborative expectations are unclear. Is the reporting requirement at the plan level or at the collaborative level? Sections 6.2.6.1 through 6.2.6.6 strongly suggest a collaborative project with other contracted plans, whereas sections 6.2.6.7 and 6.2.6.8 suggest reporting will be done at the individual plan level. If this is a collaborative effort, wouldn't a collaborative report be the most efficient reporting vehicle? As all PIPs include the requirement to establish the applicability of the selected topic(s) through data analysis, will HCA be supplying the necessary background data with the rationale behind the topic selection to the collaborative prior to the commencement of this activity?	PIP	This is in addition to the financial support provided to the Department of Health. The MCOs are certainly encouraged to look at all opportunities for collaboration on the Transitions PIP, including consideration of collaborating with the Department of Health on the Transitions PIP. We have a strong belief that the MCOs can collaborate effectively on this project and look forward to reviewing the design of the PIP in the future. The MCOs are required to conduct their own data analysis to support the efficacy of the study. The HCA may consider reporting at a collaborative level, but may need to obtain a waiver from the federal government to waive reporting at the plan level.
This section references a -Standardized Screening and Intervention for Depression PIP‖, yet there is no mention of this PIP in Section 6.2 or anywhere else in the draft contract. Was the intention to reference the Transitional Healthcare Services PIP, or is there another objective for this requirement?	PIP	The HCA will reflect on the language in 6.6.2. and modify accordingly.
• With this needed integration in mind, consider limiting the number of plans in each community. A smaller number of plans will mean more efficiency and less complexity when working with the many community services that support the health care of Medicaid persons: behavioral health care systems, social services, and housing services to name a few.	Plan Limitations	Thank you for your comment. HCA will take this under advisement
• We recommend a firm restriction on profits that a plan can keep. Although some people feel that the profit motive is an effective strategy for limiting health care costs and improving quality, in our opinion this is far from a proven concept. Our experience is that this tends instead to lead to harsh restrictions in care and, even more of a problem, attempts to claim a high needs client is simply not the plan's responsibility. Limiting profits and administrative overhead and instead requiring cost savings be spent on quality improvement will offer adequate incentive to a plan without encouraging harmful practices.	Plan Limitations	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 7. We noted that throughout the contract, requirements for policies and procedures have been deleted from individual sections. Is the general language in Section 7 intended to be equivalent (i.e., relate to all sections of the draft contract to the same extent as the current contract)? Will the policies and procedures of each plan be publicly available?	Policy	It is HCA's expectation and a contract requirement that contractors develop, implement and monitor compliance with a full set of policies and procedures to guide staff and subcontractor's behavior in fulfilling the requirements of the contract. We expect and require that staff and subcontractor's be trained on those policies and procedures. We expect and require that the Implementation and Operations Plans required by the RFP address the expectation and requirement. HCA will review policies and procedures in the readiness assessment.
We are concerned that the RFP and Contract do not require health plans to be responsive to unique local conditions. To ensure that the current and future healthcare delivery systems are responsive to unique local conditions, expertise and energy, we recommend that the Washington Healthcare Authority writes RFPs and develops Contracts that encourage and support Regional Healthcare Authority structures throughout Washington State.	Populations	Thank you for your input.
Is there a requirement to stay enrolled for a particular time frame?	Populations	No
My question is whether or not there is any possibility that HCA would make an exception to the requirement that plans participating in the procurement process must already have a Medicaid contract in "some state." It appears that an unfortunate side effect of this requirement is to prevent a Washington health plan from participation, while health plans from other states who are new to Washington are allowed. That requirement effectively precludes participation of plans like Puget Sound Health Partners (PSHP), incorporated and licensed in Washington, employing Washington residents, and caring for Washington Medicare Advantage beneficiaries. We completely understand the value of a plan already having Medicaid experience, and many of our staff do, even though we as a plan do not. We have been in business since 2008, are financially sound, and our members have given us high marks for customer service. I'd like to know if there's any way we can discuss the possibility of a waiver to this requirement so that Puget Sound Health Partners might have the opportunity to apply for participation. We do recognize and appreciate that we must respect public process and regulation that assure the state contracts on behalf of its residents with trustworthy organizations.	Populations	No. HCA believes that experience serving the Medicaid population is essential.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

What populations will be included in the RFP? Will eligible enrollees be identified in the contract and/or RFP? Is the Washington Health Program included in the RFP? Will new populations be incorporated into the HO population, or will they be separate lines of business? If the SSI population is added, will they be included in the HO benefits package i.e. medical only, or will mental health and chemical dependency also be included for these members. If not, will SSI be a separate line of business? If the SSI population is added, will they be risk adjusted? If so, what risk adjustment methodology will be used?	Populations	Populations will be clearly defined in the published RFP,
3. Background: We heard recently that no final decisions have been made about including the SSI clients in managed care. Will final decisions be made at the time of release of the final RFP documents?	Populations	Populations will be clearly defined in the published RFP,
Washington has not reprocured the current Health Options managed care program in over 10 years. Although Washington has a mature Medicaid managed care program in place, the expansion of the Health Options population to include the enrollment of the SSI population requires managed care organizations to have the infrastructure, network and clinical models in place to meet the unique needs of this vulnerable population	Populations	Thank you for your input.
Sections 12.6.7 and 12.7. Enrollees with special health care needs - if the SSI-related/ABD population is included in this contract, the process of identifying these individuals should be strengthened. This pro-cess may also apply to MCS enrollees if that population is included in the contract. HCA will be fully aware of those meeting the disability criteria and therefore should identify them rather than leaving it up to the MCOs. State identification of these individuals before or at the point of entry into managed care will allow for greater continuity of care for enrollees with special health care needs.	Populations	HCA systems and enrollment information provides categorical information on enrollees.
What is your estimate of newly eligible clients?	Populations	This information will not be available until the RFP is released.
Is there any cost sharing? If so how is that determined?	Populations	Cost sharing will be initially structured as it is now. Basic Health has cost sharing and Healthy Options does not.
For new entrants in the market, in order to ensure viability and sustainability, it is important to have a baseline of at least 50,000 members if selected. Please clarify the minimum members to be distributed to new health plan entrants.	Populations	This information will not be available until the RFP is released.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Medicaid Managed Care Expansion – adding non-dual eligible SSI lives- Is there a way to broadly estimate what this Managed Care expansion represents in terms of costs (either perhaps for the total number of lives transitioning (110,000??), or perhaps on a per-member-per month basis)? While it seems that the specific number here would probably have to wait until the final RFP is released, in the meantime, I was just looking for a very broad estimate if possible	Populations	This information will not be available until the RFP is released.
Medicaid Managed Care Expansion – adding non-dual eligible SSI lives- How many SSI lives does this represent? Based on the link below, it looks like this would represent about 110,000 lives transitioning to Managed Care, does that sound in the ballpark?	Populations	Yes, this is correct.
Also, regarding the new populations, it would be helpful to understand what the retention assumption is for this population – is it assumed that most individuals stay eligible for 6 months, 1 year or even longer.	Populations	Demographic information on the included populations will be available with the published RFP.
The title of the draft Contract includes -Disability Lifeline,‖ however this population is not identified within the draft RFP or draft Contract. Please provide additional information on HCA‘s intent regarding this population‘s inclusion in the upcoming joint procurement.	Populations	Information regarding included populations will not be available until the RFP is published.
Contract Section 12.5 Transitional Care: This whole section includes new requirements to have written operational agreements and coordination with other State agencies that have been given primary responsibility for administering the benefit such as with RSN‘s and Community Drug and Alcohol Treatment programs. Please provide confirmation that these agencies are aware of this requirement and have similar requirements to work with us in this regard. Most of the requirements addressed in this section are primarily delivered through these agencies. As contractors we typically provide some of the outpatient treatment for these services and agree that better care coordination is important, however the requirements of this section seem to include that we provide the assessment and care plan for these members. Please provide further clarification about these requirements and expectations for us working with the State agencies that have primary responsibility for these services.	Populations	HCA is working with our partners to include reciprocal language in contracts with coordinating entities. We will clarify the expectations for coordination.
Please include contract guidance regarding disenrollment/re-enrollment for members eligible for SSI. More specifically, the effective date for SSI eligibility. Our preference would be retroactive enrollment for newborns to 120 days.	Populations	Thank you for your input. The published RFP sample contract will be clear about the timing of SSI enrollment.
Contract includes WBH and disability lifeline. Please provide definitions and background as to why populations are being included.	Populations	Information regarding included populations will not be available until the RFP is published.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Does Disability Lifeline mean Social Security Income? If so, does that mean health plans will take on children, adults or both?	Populations	Information regarding included populations will not be available until the RFP is published. The Disability Lifeline program is operated under a federal waiver and the population is separate from the SSI population. Disability Lifeline is for disabled adults who do not currently meet SSI requirements.
RFP states enrollees of the PRC cannot change their plan for 12 months (i.e., lock-in). Is this program intended for high ER or drug utilizers? If so, perhaps the state should allow plans to assign one physician, one hospital, one pharmacist for PRC enrollees.	PRC	Please review the referenced Washington Administrative Code and federal citations for the PRC program.
Regarding the –Patient Review and Coordination (PRC)‖ -- are adults and children eligible for this? What are the eligibility criteria?	PRC	Please review the referenced Washington Administrative Code and federal citations for the PRC program.
13. Please describe the timeframe for which plans may submit successful QAPI experience (i.e. the last 3 years, 5 years, etc.).	QAPI	The timeframe will be clarified in the published RFP.
2. When/where will the –Rates Requirements‖ info be available?	Rates	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published.
When/where will the –Rates Requirements‖ info be available?	Rates	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published.
1. An encounter based fee component should be paid as a fee for service or integrated into enhanced capitation payments. 2. A quality based fee component paid for open access to care and providing comprehensive coordinated medical home services should be paid by an additional per member per month fee, or a fee schedule increase. 3. A cost containment performance fee or pay for performance should be paid as a bonus, either on a per member per month basis or a fee schedule increase	Rates	Thank you for your input.
Section 5.14 has been left blank in the draft contract. Please confirm the detailed methodology from the RFP Section E will be provided in this section when the document is released with the joint procurement?	Rates	Any parts of the RFP and Sample Contract not available for the draft will be available when the RFP is published.
If the bidder is statewide, will there be only one rate?	Rates	The rate bidding information, structure and methodology will be available when the RFP is published.
Are the expectations that Medicaid and Basic Health will be paid at the same rates? Typically there has been a higher differential for Basic Health in recognition of the additional administrative burdens imposed related to administration and collection of cost sharing requirements.	Rates	The rate bidding information, structure and methodology will be available when the RFP is published.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Currently the Healthy Options plans are required to pay critical access hospitals their hospital's interim payment rates, but are not required to do a cost reconciliation such as is done for fee for service. This may become a bigger issue as a greater proportion of services are under managed care. Will there be provision or requirement for reconciliation?	Rates	No
Currently payments by managed care plans to hospitals must reflect the payment increases funded through the hospital safety net assessment program. There is no such provision in the RFP contract. Will this be addressed?	Rates	Yes
COST: Will the state provide separate rates for the special needs plans and for the developmentally disabled? Will the rates be released before the RFP is due? Will the state provide rate data books?	Rates	The rate bidding information, structure and methodology will be available when the RFP is published.
9. Describe how any changes to the rates will be made if benefit design changes are made.	Rates	The rate bidding information, structure and methodology will be available when the RFP is published.
In the informal pre-RFP meeting on March 21st, we learned rates would be different for some populations (e.g. SSI) and in some cases benefit packages will be different (e.g. HO, BH). Can you clarify if the new populations in the RFP (SSI, etc.) will be folded into the HO line of business, or will they become separate lines of business? We appreciate any information you can provide, thank you.	Rates	This information will not be available until the RFP is released.
How are rates determined?	Rates	Rates are developed by our actuaries using actuarially sound methods.
Basic Health Lives - On average (and again, broadly speaking), what is the per-member-per month cost here for the 40k lives that are going to be included in the re-procurement?	Rates	Rates for the program beginning July 2012 have not yet been established, however, the 2011 BH composite benchmark rate is $234.32.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

In particular, here are our concerns: 1. In the RFP, section 2 on Program Requirements, section h on Understanding the Changing Landscape of Managed Care would be an appropriate section in which to require that applicants explain their plans for contracting with providers identified as Essential Community Providers under the federal Affordable Care Act. Providers who are federal 340(b) program-eligible, including most Washington low-income family planning providers, are identified as Essential Community Providers under the Affordable Care Act, with whom all insurance providers that offer plans in the insurance exchange must contract. 2. In the contract document, it was our understanding that the Medicaid Purchasing Administration would promote and incentivize contracting with family planning providers, based on our current knowledge that many Healthy Options plan enrollees currently come to non-contracted providers such as Planned Parenthood after being told that they must wait for lengthy periods for an appointment for an urgently needed birth control refill. 3. Specific appointment, distance, and ratio standards for family planning services should be included in the contract under Appointment Standards, (Section 5.7, starting page 50), Provider Network - Distance Standards, (Section 5.9, starting page 51), and Standards for the Ratio of Primary	Contract/RFP	Thank you for your comment. HCA will take this under advisement
3) We would request that the risk adjustment scheme used for the new populations be transparent to the extent that it is clear how the claims data roles into the rate structure that is used.	Risk Adjustment	Thank for your input. We strive to make all of our processes as open and above board as it is possible for them to be.
• Continue and perhaps even expand the requirements for the plans to work with the RSNs. Such collaboration would best require ongoing efforts from both parties to integrate care at both the individual and population levels.	RSN	Thank you for your comment. HCA will take this under advisement
Can we use our own Rx formulary?	RX	Currently plan formularies are subject to review and approval by HCA.
In the draft RFP Section E and Section D appear to be ordered incorrectly.	Section Numbers, spelling, etc.	HCA will review this and make corrections when applicable.
There appears to be a typo in the second sentence of Section 4.1.3.	Section Numbers, spelling, etc.	Thank you for your comment. HCA will review this.
There is a missing section number in a subsection under Section 12.4.4 of the draft Contract.	Section Numbers, spelling, etc.	Thank you for your comment. HCA will review this.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Topic: Service Area On Page 19, in Section 2- Program Requirements, item B. Access to Care and Provider Network Area - the DRAFT RFP document states that -Bidders are reminded that they may not bid for part of a Service Area.‖ Healthy Options contractors have been able to cover partial service areas in an effort to promote access and choice for HO members. With the move towards Medical Home models and Accountable Care, we believe that it is important to have and develop relationships with providers and provider groups that will support and encourage these models. As a result, it may be that a plan may not want to bid to cover a full service area. Would the HCA be willing to consider flexibility with this requirement if there are more than two plans covering a specific service area? Will the contract still allow for a contractor to request changes to service areas and capacity?	Service Area	Yes, will we allow changes in our interest.
Question The language contained in this section favors managed care plans that enter a new service area over plans who have continually served an area over one or multiple years. Can this language be revisited to be more equitable for all plans participating within a service area?	Service Area	No, it is HCA's intent to encourage entry into new service areas.
Will HCA please provide additional definitions (county listings) for the specific geographic service areas to be used in the procurement?	Service Area	This information will not be available until the RFP is released.
Please provide clarification on how HCA defines Service Areas. (Section 1.76 of the draft contract states only -geographic areas in which the Contractor serves eligible clients‖). It appears 6 different reports are required for each access standard (for 5, 10, 15, 25, 35 and 50 miles), which seems cumbersome when one report indicates the miles to a provider from 0 miles to as many miles needed to find a provider. Can you provide clarification? Can we have data for all Service Areas we are bidding on in one report or are separate reports required for each Service Area?	Service Area	This information will not be available until the RFP is released.
Can clients seek services out of area?	Service Area	We will assure that the provision of services outside the service area is clear in the publish RFP Sample Contract.
Please confirm that the HCA will award contracts on a regional geographic service area basis. Additionally, will each geographic service area be scored and evaluated separately?	Service Area	HCA will award contracts on a service area basis. No, each geographic area will not be scored and evaluated separately.
Section 4.7. We expect you will revise this section to conform to SSB 5927, enacted recently	SSB 5927	HCA will updated sections to conform with SSB 5927 where appropriate.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Will HCA please provide more information regarding the TEAMonitoring process?	Team Monitor	The HCA will provide more information on the TeaMonitor process following Contract execution. We have attached an historical letter sent to the CMS regarding our TeaMonitor process for your information. The document is entitled: HCA of WA CMS Protocols-Public Comment 5409.doc.
The contract states 2 business days. According to WAC 284-43-410 the new state requirement is 5 calendar days.	WAC	The HCA has modified language to reflect this changed requirement.
The language in this section changes the urgent authorization turnaround time from 72 hours to 24 hours. We understand WAC 284-43-410, which includes this change, is out for comment and may be changed due to concerns raised by providers and plans. Please update the contract change to reflect the final WAC language.	WAC	Thank you for your comment. HCA will take this under advisement
Section 11.1.2. To the rules with which Contractors must comply in assisting enrollees should be added DSHS's -Equal Access‖ (NSA) rules, WAC 388-472-0010 through -0050.	WAC	Thank you for your comment. HCA will take this under advisement
Sections 11.2.2. – 11.2.5. These provisions derived from the health carriers and health plans regulations in WAC Chapter 284-43 should not be limited as -specific to the grievance process,‖ but must also be made equally applicable to -appeals‖ (11.3) and -hearings‖ (11.5). WAC 284-43-615(1) itself requires each carrier to –adopt and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations‖ (emphasis added). Moreover, for purposes of those regulations (with which section 11.1 requires Contractor compliance), -grievance‖ is defined more broadly than in the federal and state Medicaid managed care regulations, to include any written or oral disagreement with -Denial of health care services or payment for health care services.‖ WAC 284-43-130(11)(a); in other words, in those rules, –grievance‖ also includes what the Medicaid managed care regulations call -appeals.‖	WAC	Thank you for your comment. HCA will take this under advisement
Section 11.3.4. Consistent with DSHS's rule that applies generally to continued benefits when a hearing is requested and with Contract Section 11.8.1.1.2., this provision should read that –an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action or before the effective date of that action, whichever is later.‖ See WAC 388-458-0040(3)	WAC	Thank you for your comment. HCA will take this under advisement
Section 11.5.2.1. As with appeals, this provision should provide that hearings may be requested either orally or in writing.	WAC	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

I am a consultant with the Boston Consulting Group and am trying to find out if it is possible for a health insurer to operate Medicaid plans that are only open to dual eligibles. Are there states that allow companies to offer plans to only dual eligibles (e.g., that are not open to other Medicaid populations)? I am hoping there is a report or source on the CMS website, but finding one has proven to be difficult. 1.) Would Washington Medicaid contract with a payer who only provides Medicaid to duals in either one of these two scenarios: a) A payer who was part of the state's integrated plans, but that only provided Medicaid within that plan and not to any other Medicaid eligibles b) A payer who wanted to provide Medicaid to only the dual eligible portion of the population 2.) Is Washington open to working with new health insurers to offer Medicaid plans (integrated or not)?	Dual Enrollees	We currently have no integrated managed care option for dual eligibles. We are working in that direction, but we will not be there in the short-term. We will soon be releasing a Request for Proposal for Medicaid managed care. Here is a link to the website with the details of that procurement http://www.hca.wa.gov/procurement.html. If you have questions about the procurement, the website is the official conduit for asking those questions.
I would suggest that all Plans be required to have identical formularies, formulary management policies and procedures	Comment	Thank you for your comment, there is currently no plan to adopt a uniform formulary.
Section 8 (subcontracts) and especially 8.9 should include requirements from SB 5394, primary care health homes including those in sections 4 and 5 of SB 5394. These two sections amend RCW 74.09.5222 and RCW 70.47.100 (see below): SB 5394 requires that the contractor implement payment methods to incent health homes - especially for clients with chronic care conditions. This is to prompt movement from FFS to other payment methods, such as sub-capitation, a care coordination fee, incentive payments, etc. The language is silent on the particular payment method; but does require that one that incents PCHHs be used. The language goes on to require incentives for reducing inpatient and ER use. MPA could also add other similar measures to promote effective chronic care management. You'll note that SB 5394 (2)(e)(i)(E) requires that the contractor promote participation in the DOH medical home collaborative training. Appears to be addressed in Sec 8.11 of the contact.	Health Homes	Thank you for your comment. HCA will take this under advisement

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

Section 5.5 Network Adequacy: SB5394 Sec. 2(8) - Definition of health home. The goals is to require the development of primary care capacity to serve clients outside the normal 9-5 office hours. This could be urgent care services, groups of PCPs sharing the load for providing services in non-routine hours, a nurse hotline, etc. The reason for this is to provide clients a realistic alternative to ER use. it's understood that this would require increased upfront payments to PCPs coupled to reduce ER use.	Network/Service Area	Thank you for your comment. HCA will take this under advisement
HEDIS - there are a lot of measures in here - does it make sense to narrow down the priority ones and then have incentives or penalties for performance on those measures?	Performance Measures	Given the addition of new populations in the Healthy Options requirement, the HCA has added HEDIS measures. The HCA is revising the performance measures in an attempt to reduce administrative burden. Three sets of measures will be published: 1) Measures required annually; 2) Adult measures required to be produced in even Contract years; 3) Child measures required to be produced in odd Contract years.
Health Info: this section should include or at least incorporate by reference requirements in SB 5346 (2009) - Health Information Exchange	Health Information	Thank you for your comment. HCA will take this under advisement
Section 8.12 Claims Payment Standards: this section needs to include the provisions in sections 9 and 10 of SB 5346 (2009) Administrative Simplification. This statue has specific requirements for compliance with statewide standards.	Claims Payment	Thank you for your comment. HCA will take this under advisement
Section 8.14 Credentialing: should definitely include the credentialing requirement in section 6 of SB 5346 - especially since the credentialing module is fully operational now.	Credentialing	Thank you for your comment. HCA will take this under advisement
Section 10 Utilization Management: this area should also be consistent with standards developed under SB 5346 - Section 2 (Definitions) and Section 10 for specifics	Utilization Management	Thank you for your comment. HCA will take this under advisement
Section 12.5 Transitional are: the definition of "Health Home" in SB 5394 includes requirements that should be incorporated here	Transitional Care	Thank you for your comment. HCA will take this under advisement
Section 12.6 Coordination of Care: you might want to synchronize the language with the related sections in 5394.	Coordination of Care	Thank you for your comment. HCA will take this under advisement
Service areas for the procurement RFP: what are they and how are they established	Network/Service Area	Service areas are primarily counties, but for Healthy Options there are some adjustments for not dividing zip codes and to accommodate where care is received.
3. Revised network adequacy requirements, particularly with regard to hospital-based physician services, consistent with the requirements of ESSB 5927 (Ch. 9, Laws of 2011, 1st Sp Sess)	Network/Service Area/Legislature	This is currently under development.

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

4. RFP provisions regarding primary medical homes and chronic care management, consistent with the requirements of ESSB 5394 (Ch. 316, Laws of 2011)	Medical Homes/Chronic Care/Legislature	The language for medical homes and chronic care management is under development and will be available when the RFP is published.
The procurement webpage http://www.hca.wa.gov/procurement.html indicated that questions submitted regarding the draft RFP would be available on the website. Are any Questions and Answers (besides the May 5 document) or comment going to be posted?	Miscellaneous	An updated list of questions and answers will be posted on our procurement website as they become available.
Please modify the following question previously submitted on Tuesday 6/21 (changes in red font). • Given the delay and amount of retroactivity involved in the Healthy Options 2011 rate setting, the large volume of questions/comments received by HCA which require response, the hospital assessment changes, the fee schedule changes, the legislative benefit changes and the transition of MPA to HCA, is there a chance release of the RFP will be delayed past July 2011? If so, what is the estimated release date? Please note our staff want to make vacation plans around important RFP dates and would like to know as soon as possible if there will be changes to the expected RFP timeline.	Dates	
• The Draft RFP requirements for Binder 2 (Quality) include: Submit a staffing plan for the QAPI program. For persons currently on staff with the Bidder, provide names, title, qualifications and resumes. For staff to be hired, describe the hiring process and the qualifications for the position. Does -persons currently on staff with the Bidder‖ refer to management only? If not, please clarify if resumes are required for staff below the management level. Does -staff to be hired‖ refer to management level positions only? If not, please clarify if -staff to be hired‖ refers to staff below the management level.	Binder	

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

As we prepare for future business in Washington the process and tools around risk stratification is very important to our personal care model as with all timely access to data. We are interested in a public DEMO of the existing risk stratification tool used by the state called PRISM. DSHS Demo of Stratification – Prism. DSHS has developed a tool to create individual patient histories and for risk stratifying using claims, pharmacy and other data sources and they will assign a risk score to each SSI member assigned. The tool uses CDPS methodology; it is called the Prism System. They will demo for us in March. Dave Mancuso at DSHS is the point of contact. If you could direct us to the right resource or schedule something within the next two weeks would greatly help our efforts in analyzing market needs.	PRISM	
How will Washington‘s waiver proposal submitted to HHS Secretary on April 29, 2011 to seek more flexibility in the management and savings for its Medicaid program impact HCA‘s planned joint Healthy Options and Basic Health reprocurement? Does HCA envision any changes to the current Healthy Options and Basic Health planned procurement in terms of populations to be served, benefit packages and reimbursement models as a result of the waiver? We understand that the anticipated timeline for HHS‘ approval of the new waiver request is September 1, 2011. Will this timeline or proposal impact HCA‘s previously communicated timelines for the procurement?	Contract/RFP	
Why don't you guys upgrade to holistic health and 360 insurance that does it all like other parts of the USA?	Miscellaneous	

JOINT PROCUREMENT VENDOR QUESTIONS MATRIX

WellPoint's State Sponsored Business unit is interested in possible Medicaid/SCHIP contract opportunities in the State of Washington, and we would appreciate your assistance. We understand that the State intends to release a formal Request for Proposal in the month of July. To help us with our analysis of the opportunity, we would like to request the following information: --2009, 2010 and 2011 rates for each plan --any 2009, 2010 and 2011 actuarial data books or rate adjustment letters --current ‐capacity matrix‖ showing the capacity for each plan and enrollment by county Please let me know if this email is sufficient for this type of data request or if I need to fill out additional documentation. Thank you for your assistance and please feel free to contact me if you have any questions or concerns.	Rates	
Please provide a link for the draft Medicaid managed care RFP.	Contract/RFP	
• Is HCA planning to include the Disability Lifeline population in the RFP and new contract? If not, is it planned for the future and if so, what is the estimated date it will be included in the contract?	Populations	Populations will be clearly defined in the published RFP,